II - NEEDS ASSESSMENT

B. Five Year Needs Assessment

1. Process for Conducting Needs Assessment

The original Tennessee Department of Health plan called for the Maternal and Child Health (MCH) Needs Assessment to begin on July 1, 2004. Starting in January 2005, MCH sent two representatives to the Maternal Child Health Bureau's Technical Assistance meeting in Atlanta. In March 2005, MCH staff met internally to develop project role and responsibilities for MCH staff and contractor staff, develop a timeline for deliverables, and identify potential Advisory Committee members. Due to a series of delays in finalizing the contract between the State of Tennessee and Middle Tennessee State University (MTSU), research could not begin before November. These delays required curtailing a number of the original research plans (e.g., a reduction of focus group meetings with MCH clients from 24 to 13).

In early November, the study's Principal Investigator and Project Coordinator met with the Director of the Tennessee Department of Health's Maternal and Child Health Section (TDH-MCH) and members of her staff. We agreed that the assessment would focus on National Performance Measures, Tennessee Performance Measures, questionnaire-surveys and focus group meetings relevant to Tennessee health care delivery professionals and the clients of relevant MCH agencies. We also determined that the project would include both quantitative and qualitative analyses.

Specifically, we identified MCH-relevant national and state data sets, developed written questionnaires for health professionals identified by TDH-MCH, established a strategy for assembling focus groups consisting of MCH-care recipients residing in all major areas of Tennessee, and constructed questionnaires to be filled out by focus group members. Where relevant, professional and client surveys contained items directly related to National and/or State Performance Measures and MCH HP2010 indicators. Findings from these sources were presented at a statewide MCH Stakeholders Meeting on April 22, 2005.

Throughout this needs assessment process, members of the MTSU Needs Assessment team worked in close partnership with TDH-MCH. Meetings and/or conference calls occurred on almost a monthly basis. In addition to these exchanges of information, all MTSU study instruments, research procedures, and data sources were authorized and approved by the Director of TDH-MCH.

TECHNICAL EXPERTISE

This MCH needs assessment was conducted by the Center for Health and Human Services at MTSU. The study's Principal Investigator (PI), Project Coordinator (PC), and two graduate research assistants are directly affiliated with the Center. In order to fulfill contractual requirements for this project, the Center formed a research partnership with MTSU's Sociology and Anthropology Department. The Department provided the Center with part-time help from three faculty members and two graduate research assistants.

The PI possesses a Ph.D. in Social Psychology and is a specialist in Medical Sociology. He has published numerous articles relating to Mexican-American health and mental health issues. He has recently conducted a mental health survey of elderly Hispanics and non-Hispanic white residents of El Paso County, Texas. The Project Coordinator (PC) has a M.A. in Health and Human Service Administration. She has extensive experience in MCH issues and has been directly involved in MCH needs assessment projects in Minnesota and Tennessee. She is a childbirth educator and serves on the Rutherford County Success by Six Steering Committee. The PC also possesses broad experience in conducting focus groups and in qualitative data analysis. Of the three Sociology faculty members, one is a demographer. A second faculty member is a medical sociologist/gerontologist. These two researchers possess expertise in quantitative methodology, statistical analysis, and working with large datasets. The third faculty member is a specialist in focus group research and qualitative data analysis.

DATA COLLECTION AND ANALYSIS

Process

Data collection included the use of MCH-related websites, the development and distribution of a Professional Stakeholder Survey (Appendix B), the construction of a brief survey for focus group participants (Appendix C), and the formulation of a standard set of open-ended questions to be asked at each 90-minute focus group session. As noted above, all data gathering, survey instrument development, and focus group information gathering was directly tied to the National and State MCH Performance Measures, and, to a somewhat lesser extent, HP 2010 MCH-related outcomes. The entire data-gathering process was also profoundly influenced by information obtained in meetings with TDH-MCH staff members.

Data Gathering – Quantitative Data.

The research team simultaneously conducted a multifaceted approach to data gathering. Two Sociology team members and a graduate research assistant searched a number of national and state websites deemed relevant to the 18 National and eight State Performance Measures (Figures 1 and 2), and to HP 2010 (Figure 3). The PI and PC developed two survey instruments; a Professional Stakeholders Survey (Appendix B) and a questionnaire for focus group participants (Appendix C). An open-ended questionnaire to be used in focus group sessions also was prepared.

Preexisting Data Sources

A number of website sources played a crucial part of our performance measure comparisons between Tennessee and the nation. Data gleaned from these sources are presented, in conjunction with our own survey findings, as we address Tennessee's MCH health care performance.

The Professional Stakeholder Survey

A statewide list of 329 MCH professionals was obtained from TDH-MCH. These professionals represented the TDH and other public agencies as well as various private health and social service organizations. Upon completion and final endorsement of the MCH Professional Survey by the TDH-MCH, this 58-question instrument was mailed or emailed to all 329 professionals, along with a motivational letter signed by the Director of Maternal and Child Health (Appendix B). Of these 329 professionals, 169 (50%) returned completed questionnaires.

These 169 MCH professionals represented the following agencies:

Tennessee Department of Health	66%
Private health care agencies	13%
Head Start	8%
Tennessee Department of Children's Services	6%
Tennessee Department of Education	4%
Private social service agencies or organizations	2%
Tennessee Commission on Children and Youth	.5%
Tennessee Department of Mental Health	.5%

Survey respondents also represented a variety of professional positions:

Executive or program director	28%
Social worker	21%
Categorized as: "coordinator: client services or educator"	17%
Nurse	16%
Categorized as: "coordinator: manager	9%
Clinician (other than nurse or social worker)	9%

Forty-seven MCH issues were included on the Professional Stakeholder Survey. A glance at these issues confirms the great extent to which this needs assessment study was influenced by the national and state performance measures, and the HP 2010 outcomes. Respondents were asked to "check" one or more of five "boxes," shown in Figure 4, related to each of the 47 issues.

Figure 4. Professional Stakeholder Survey – Issue Responses

Issue	(A) Highly Important to Community or Region	(B) Highly Important to Significant # Clients	(C) Agency Currently Addresses Issue	(D) Agency Does Good Job on Issue	(E) Agency Doesn't Address but Should

Box "A" was checked if respondent felt that the issue in question was highly important to her/his agency's community or region.

Box "B" was checked if respondent felt that the issue would be considered highly important by a significant number of her/his clients.

Box "C" was checked if respondent's agency currently addressed this issue.

Box "D" was checked if respondent's agency did a good job in addressing the issue.

Box "E" was checked if respondent's agency did not address the issue, but, in her/his opinion, should address the issue.

In order to further address the salience of these 47 issues, each respondent was asked five questions shown below. (These appear as questions 48-52 on the Professional Stakeholder Survey, found in Appendix B.)

"Looking over the list of issues you marked HIGHLY IMPORTANT to… community or region, determine…the three issues you consider…**MOST IMPORTANT.**"

"Looking over the list of issues you marked HIGHLY IMPORTANT to a **SIGNIFICANT NUMBER OF YOUR CLIENTS**, determine…the three issues you think your clients would consider…**MOST IMPORTANT.**"

"Looking over the list of issues you identified as **CURRENTLY BEING ADDRESSED BY YOUR AGENCY**, determine…the three issues you consider… **MOST IMPORTANT.** "

"Looking over the list of issues you identified that your **AGENCY DOES A GOOD JOB ADDRESSING**, determine… the three issues you consider… **MOST IMPORTANT.**"

"Looking over the list of issues you identified that **SHOULD BE ADDRESSED BY YOUR AGENCY** but **ARE NOT ADDRESSED AT THIS TIME**, determine…the three issues you consider…**MOST IMPORTANT.** "

Focus Groups: Selecting Locations and Client Participants

Thirteen focus groups were held in 12 locations throughout Tennessee. Two groups were held in Clarksville in order to meet with both English- and Spanish-speaking participants. Group locations were discussed in consultation with MCH staff, which determined the final meeting locations.

One hundred seventeen people participated in the focus group discussions. All participants were using at least one health department service or had used at least one service within the last 6 months. Participants were at least 18 years of age and were either pregnant women or parents of young children. Staff from the Central Office of MCH provided local contact names and phone numbers at each of the focus group sites. Most individuals were employees of a county or regional health department but a few were affiliated with Head Start or private not-for-profit groups. In our initial conversations with these local contacts we explained the purpose of the study, described the type of focus group participant with whom we wanted to speak, and requested help in recruiting participants and identifying meeting locations. Most meetings were held in health department facilities but a public library, birthing center, and community center also were utilized. All participants were given a $25 gift certificate and a meal; those who required it received reimbursement assistance for babysitting and transportation.

Table 1 depicts city and county locations, and the number of participants for each of the 13 focus groups.

Table 1. Tennessee MCH Focus Groups: Locations and Number of Participants

County	City	Number of Participants
Davidson	Nashville	7

Hamilton	Chattanooga	9
Haywood	Brownsville	11
Knox	Knoxville	11
Madison	Jackson	9
Maury	Columbia	5
Montgomery	Clarksville*	10
Obion	Union City	8
Putnam	Cookeville	11
Rutherford	Murfreesboro	10
Shelby	Memphis	16
Washington	Johnson City	10
Total Number of Participants		117

*2 groups - 1 English and 1 Spanish

According to TDH-MCH, six Tennessee counties are considered "urban." They are Davidson, Hamilton, Knox, Madison, Shelby, and Sullivan. Tennessee's remaining 89 counties are defined by TDH-MCH as "rural." By this definition, 44% of our focus group participants received services located in Tennessee' s urban counties.

Regarding ethnic diversity, the 117 focus group participants constitute an ethnically diverse sample:

42% were African American
43% were non-Hispanic white
11% were Hispanic
1% were Asian, and
3 % were of another race/ethnicity.

However, it should be noted that not all focus groups were racially heterogeneous. For example, Brownsville and Memphis focus group members were 100% and 94 % African American; Cookeville and Johnson City participants were 100% and 90% non-Hispanic white. Ages of participants ranged from 18-56 with a mean age of 30. It should also be noted that 96% of our 117 participants were female.

Figures 5 and 6 summarize two important socioeconomic status dimensions of the focus group participant sample.

In annual household income, 31% of focus group participants live in households making less than $5,000. Another 41% earn less than $20,000. More than 85% of participants reside in

households with annual incomes of less than $30,000 per year. Educationally, 26% of our participants do not hold a high school degree or GED equivalent, 32% are high school graduates and 38% have at least some college training. The average number of children, younger than 18 years of age, living at home is 2.12.

A note of caution: Although focus group participants represent Tennessee's regional, rural-urban,

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A note of caution: Although focus group participants represent Tennessee's regional, rural-urban, and ethnic variability, Focus Group Survey data presented below should not be taken as statistically representative of statewide participants in programs under review. Time did not permit even the most cursory form of mechanical sampling for either focus group locations or agency client-participants. On the other hand, strong response patterns can be observed both in responses to the Focus Group survey and in focus group discussions. These response patterns tend to be maintained across regional, racial, and rural-urban boundaries. It is the research team's opinion that these response patterns are meaningful sources of input for the TDH-MCH's formulation of its five-year action plan.

The Focus Group Participant Survey

Focus group participants were provided with a box meal at the beginning of each focus group session. Prior to the start of each meeting, participants were handed an informed consent form. This form was read orally to participants by the focus group leader (or read orally in Spanish by a translator). All participants attending the 13 focus groups agreed to conditions summarized in the informed consent document, signed their consent forms, and remained throughout the 90-minute focus group meeting. Each participant was also asked to complete the 16-question Focus Group Survey (Appendix C) prior to the formal beginning of the focus group discussion. **English and Spanish versions of these documents were readily available at all focus group meetings, along with bilingual (Spanish-English) translators at meetings attended by Hispanic participants.**

The Focus Group Survey contained several demographic measures and a sizable number of issue-related questions. Demographic variables included participant's (1) county of residence, (2) age, (3) sex, (4) household size, (5) degree of formal education, (6) race or ethnicity, and (7) annual household income. MCH service-related questions directed participants to check all of the listed MCH services which either they or their children had ever received. The series of MCH services were listed under the following four broad categories:

Women's Health
Family Planning
Prenatal Care
Postnatal Care
Child and Adolescent Health
Genetic and Newborn Screening

Adolescent Sexuality Education or Family Planning

The Focus Group questionnaire concluded with three questions that measure satisfaction and/or problems encountered with MCH services. The first question asked, "Which of the following have been problematic for you or your family in receiving needed services?"

transportation and location of services
language barriers and access to translation services
services available at varied times of day
education or knowledge about services and how to access them
insurance or ability to pay for services.

The final two questions requested that respondents rate the "overall availability" of needed services, and the "overall quality" of services received. Each of these questions was answered through a five-item, Likert-type response set.

INDICATORS OF NEED

The search for indicators of MCH needs was guided by the 18 National Performance Measures (Figure 1), the eight Tennessee Performance Measures (Figure 2), and the Healthy People 2010 MCH indicators (Figure 3), in consultation with the Director and staff of TDH-MCH. These three sources along with suggestions provided by TDH-MCH staff, provided the overall framework for online data searches, the construction of survey instruments, and focus group discussion questions..

Figure 1. National Performance Measures

1. The percentage that are screened and confirmed with conditions mandated by their State sponsored newborn programs (e.g., phenylketonuria and hemoglobinopathies) and who receive appropriate follow up as defined by their State. (National Newborn Screening and Genetic Resource Center)
2. The percentage of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN* Survey)
3. The percentage of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)
4. The percentage of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)
5. The percentage of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily.

(CSHCN Survey)

6. The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)
7. The percentage of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.
8. The rate of birth (per 1,000) for teenagers aged 15 through 17 years.
9. The percentage of third grade children who have received protective sealants on at least one permanent molar tooth.
10. The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.
11. The percentage of mothers who breastfeed their infants at hospital discharge.

12. The percentage of newborns that have been screened for hearing before hospital discharge.
13. The percentage of children without health insurance.
14. The percentage of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.
15. The percentage of very low birth weight infants among all live births.
16. The rate (per 100,000) of suicide deaths among youths aged 15 through 19.
17. The percentage of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.
18. The percentage of infants born to pregnant women receiving prenatal care beginning in the first trimester.

*Children With Special Health Care Needs

Figure 2. Tennessee Performance Measures

1. After implementation of folic acid education at state, regional, and local levels, reduce number of neural tube defects births.
2. Reduce to no more than four % elevated blood lead levels in children 6-72 months of age who are screened.
3. Reduce percentage of high school students using tobacco (cigarettes and smokeless).
4. Reduce percentage of high school students using alcohol.
5. Reduce incidence of maltreatment of children younger than 18 (physical, sexual, emotional abuse, and neglect) to rate no more than eight per 1,000.
6. Reduce number of HIV infected infants to no more than one per year.
7. Increase percentage of children with complete Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) annual examinations by three % each year.
8. Reduce proportion of teens and young adults (ages 15-24) with Chlamydia Trachmomatis infections attending family planning clinics

Figure 3. Healthy People 2010 MCH Indicators

HP 2010 16-1 Reduce fetal and infant deaths
HP 2010 16-2 Reduce the rate of child deaths
HP 2010 16-3 Reduce the rate of adolescent and young adult deaths
HP 2010 16-4 Reduce maternal deaths
HP 2010 16-5 Reduce maternal illness and complications due to pregnancy
HP 2010 16-6 Increase the proportion of pregnant women who receive early and adequate prenatal care
HP 2010 16-7 Increase the proportion of pregnant women who attend a series of prepared childbirth classes
HP 2010 16-8 Increase the proportion of very low birth weight (VLBW) infants born at level III hospitals or subspecialty perinatal centers
HP 2010 16-9 Reduce cesarean births among low-risk women
HP 2010 16-10 Reduce low birth weight (LBW) and very low birth weight
HP 2010 16-11 Reduce preterm births
HP 2010 16-12 Pregnant women gain a healthy amount of weight during pregnancy
HP 2010 16-13 Increase the percentage of healthy full-term infants who are put down to sleep on their backs
HP 2010 16-14 Reduce the occurrence of developmental disability
HP 2010 16-15 Reduce the occurrence of spina bifida and other neural tube defects
HP 2010 16-16 Increase the proportion of pregnancies begun with an optimum folic acid level
HP 2010 16-17 Increase abstinence from alcohol, cigarettes, and illicit drugs among pregnant women

HP 2010 16-18 Reduce the occurrence of Fetal Alcohol Syndrome
HP 2010 16-19 Increase the proportion of mothers who breastfeed their babies
HP 2010 16-20 Ensure appropriate newborn bloodspot screening, follow-up testing, and referral to services
HP 2010 16-21 Reduce hospitalization for life-threatening sepsis among children aged 4 years and under with sickling hemoglobinopathies
HP 2010 16-22 Increase the proportion of children with special health care needs who have access to a medical home
HP 2010 16-23 Increase the proportion of territories and states that have service systems for children with special health care needs

Data Gathering – Qualitative Data

Qualitative data were gathered at 13 focus group sessions, conducted at 12 county-city sites. The 117 focus group participants represented MCH regional and county-level agencies located in all major areas of Tennessee. Rural and urban regions were selected within each of three grand regions, West, Middle, and East Tennessee. Local MCH staff determined specific locations for the 13 focus group meetings. Focus group sessions were led by either the MTSU Project Coordinator or a Sociology Department faculty member. Each of these team members possess expertise in conducting focus group sessions. A broad set of open-ended questions was asked at all sessions, and special care was made to solicit input from each focus group participant.

2. Needs Assessment Partnership Building and Collaboration

Given the limited time frame, we could not involve community members to the extent that we had wished. However, we were able to garner community participation through interaction with focus group members in 12 locations, and through the sharing of research data during a day long MCH Advisory ("Stakeholder") group meeting in Nashville. MCH agency personnel also participated indirectly through their responses to our Professional Stakeholder Survey. Community-level MCH staff members were involved in the selection of client-participants for each focus group meeting; findings from these meetings will be shared with the agencies in question upon approval from the MCH Director.

After the Nashville presentation of preliminary MCH needs assessment findings, advisory group members participated in small group "roundtable" discussions in which these findings served as a springboard for recommending MCH priorities for the next five years. This advisory group, consisting of MCH professionals throughout Tennessee, will be ongoing and serve as a continuing resource regarding MCH decisions made at TDH-MCH.

3. Assessment of Needs of the Maternal and Child Health Population Groups

NATIONAL PERFORMANCE MEASURES – ANALYSIS AND RESULTS

The following analysis will address the National Performance Measures. Pre-existing national and/or state data will be summarized, and where relevant, will be enhanced with findings from the Professional Stakeholder Survey, the Focus Group Survey, and with information gleaned from focus group discussions. Please refer to the 18 measures and the presentation slides listed in Appendix A.

Eighteen National Performance Measures (NPMs) have been prescribed by the Health Resources and Services Administration (HRSA) as vital indicators of a state's overall maternal and child health. Although each state is given a certain amount of leeway in setting target goals for each NPM, all 18 must be addressed in the state's five-year needs assessment plan.

NPM #1. Percentage of Newborns Screened/Confirmed with Condition(s) Mandated by State-Sponsored Newborn Screening Programs and Who Receive Appropriate Follow Up as Defined by State

Tennessee has out performed the U.S. in screening, confirming, and treating newborns. 100% of Tennessee's newborns are screened for Phenylketonuria (PKU), Congenital Hypothyroidism, Galactosemia, Sickle-Cell Disease, and Congenital Adrenal Hyperplasia. 100% of confirmed cases for all these diseases received treatment. For the nation, only in the case of Congenital Hypothyroidism does the United States match Tennessee's 100% rate for screening and treatment of those diagnosed. The national percentage for PKU screening is 99%, and only 97% of confirmed cases are treated. For Galactosemia and Sickle Cell Disease the national infant screening percentages are 99% and 98%; and, for both diseases, the percentage of confirmed cases treated is 99%.

Related Findings From the Professional Stakeholder Survey and Focus Group Survey

According to the Professional Stakeholder Survey, 77% of respondents agreed that newborn screening and follow-up for infant hearing and serious genetic/medical conditions is highly important to their community or region. However, only 46% felt that this issue would be considered highly important to a significant number of their clients.

NPM #2. Percentage of Children with Special Health Care Needs (CSHCN) Age 0-18 Years Whose Families Partner in Decision Making at All Levels and Are Satisfied with Services Received

Currently, Vanderbilt University is conducting a statewide Family Voices Survey in order to address this issue. These data were not available in time for this report; data should be available within the next several months.

The team did find related data from the National Survey of Children with Special Healthcare Needs which noted the following:

14% of Tennessee's children and youth (aged 0 through 17) are classifiable as Children and Youth with Special Health Care Needs (CYSHCN). The national percentage of CYSHCN is 13%.

For Tennessee, and for the nation as a whole, neither poverty nor race/ethnicity has a sizable effect on prevalence of CYSHCN. However, it should be noted the rate of CYSHCN for Tennessee residents living below the poverty line (16%) is two percentage points higher than it is for their national counterparts.

The prevalence of CYSHCN for Hispanics is six percentage points lower than the percentage (14%) for non-Hispanic white residents of both Tennessee and the nation.

Taken as a whole, the CYSHCN percentage for Tennessee residents is either equal to, or slightly lower than, national prevalence findings for this health category.

For both age and sex, Tennessee's CYSHCN prevalence percentages are higher than those for the nation. Overall, children aged six through 17 have a higher prevalence of CYSHCN than do their younger counterparts; females are less likely to be classified as CYSHCN than are males.

Related Findings From the Professional Stakeholder Survey

Tennessee MCH professionals were asked to what extent they felt that NPM #2 was highly important to either their community/region or to a significant number of their clients. Forty-seven percent perceived this issue to be highly important to their community, and 43% felt that a significant number of their clients would find this NPM highly important as well.

NPM #3. Percentage of Children with Special Health Care Needs, Age 0-18 Years, Who Receive Coordinated, Ongoing Comprehensive Care Within a Medical Home.

According to data from the NSCSHCN:

- 19% of Tennessee's CYSHCN families and 22% in the U.S. have problems getting needed specialty care.
- 11% of Tennessee's CYSHCN families and 11% in the U.S. do not have a personal doctor or nurse.
- 8% of Tennessee's CHSHCN families and 9% in the U.S. rely on hospital emergency rooms for basic medical needs because they lack a stable health care source.
- 31% of Tennessee's CYSHCN and 34% in the U.S. are without family-centered care.

Thus, existing data indicate that, in comparison to the nation, Tennessee's performance on this issue is slightly better. As is the case of data for NPM #2, this issue will be further addressed in the statewide Family Voices Survey.

Related Findings From the Professional Stakeholder Survey

Findings from our Professional Stakeholder Survey reveal that 47% of the 169 MCH professionals believe that NPM #3 is highly important to their communities/regions; 43% believe that this issue is also highly important to a significant number of their clients.

NPM #4. Percentage of Children with Special Health Care Needs, Age 0-18 Years, Whose Families Have Adequate Private and/or Public Insurance to Pay for Needed Services.

Due at least partly to Tennessee's TennCare program, a relatively high proportion of the state's CYSHCN families have health insurance. Data from the NSCSHCN indicate that:

- 3% of the State's CYSHCN families are "currently" uninsured: the national percentage is 5%.
- 8% of Tennessee's CYSHCN families were without health insurance at some point during the year prior to the survey; the national rate is 12%.
- Possession of adequate coverage is another matter: 38% of the State's CYSHCN families are insured but with inadequate coverage; the national percentage is 34%.

In terms of financial hardship and quality of life for CYSHCN families, the national picture tends to be somewhat brighter than that for Tennessee. According to the NSCSHCN:

- 12% of Tennessee's CYSHCN families and 11% nationally pay $1,000 or more in medical expenses per year.
- 24% of Tennessee's CYSHCN families and 21% nationally experienced financial problems because of their child's health needs.
- 17% of Tennessee's CYSHCN families and 14% nationally spend 11 or more hours per week providing and/or coordinating health care for their child.
- 29% of Tennessee's CYSHCN families and 30% nationally were forced to cut back on work or to stop working all together, because of a child's special health care needs.

Related Findings From the Professional Stakeholder Survey and Focus Group Survey

Surprisingly, possession of health insurance for CSHCN families was considered highly important to their communities or region by only 44% of the MCH professionals; 47% felt this issue to be important to a significant number of their clients. This finding might be explainable by the fact that few professionals in our survey work exclusively with CSHCN families.

At every focus group meeting, participants identified possession of TennCare or affordable health insurance as a high priority for their families and for other members of their communities.

"For instance, my son has a special bed because he has seizures so bad. He has to sleep in it because it is totally enclosed. That bed was $10,000. Had it not been for TennCare paying for that, God only knows what would have happened to my baby…Who can buy a bed for $10,000? I sure couldn't have." Cookeville focus group participant and parent of child with special health care needs

NPM #5. Percentage of Children with Special Health Care Needs, Age 0-18 Years, Whose Families Report Community-Based Service Systems are Organized So They Can Use Them Easily

According to the NSCSHCN:

- 16% of Tennessee's CYSHCN families and 18% nationally have one or more unmet need(s) for a specific health care service.
- 22% of Tennessee's families and 23% nationally did not receive all needed respite care, genetic counseling and/or mental health services.
- 19% of Tennessee's CYSHCN families and 22% nationally had problems procuring needed specialty care.
- 11% of Tennessee and national CYSHCN families did not have a personal doctor or nurse.

Perhaps because of TennCare, the state's performance on this issue is s slightly better than that for the nation's Medicaid program in general.

NPM #6. Percentage of Youth with Special Health Care Needs Who Receive Services Necessary to Make the Transition to All Aspects of Adult Life

No direct findings for this performance measure could be found. However, information summarized under National Performance Measures #3, #4, and #5 indirectly indicate that both Tennessee and the U.S. have a long way to go before this issue is adequately addressed.

Related Findings From the Professional Stakeholder Survey and Focus Group Participants

Almost half (48%) of the 169 MCH health care professionals in our survey felt that NPM #6 was a highly important issue to their communities and/or regions. However, only 38% believed that this issue would be highly important to a significant number of their clients. Again, since most of these professionals may have relatively few CYSHCN families as clients, the results may not hold a great deal of salience for them on this issue.

Focus group members did address this issue by desiring that a number of these services be extended to youth older than 20 years of age.

NPM #7. Percentage of 19-35 Month Olds Who Have Received a Full Schedule of Age Appropriate Immunizations Against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B

According to Kids Count (2004), 81% of Tennessee's two-year-olds were immunized in 2002, versus 79% for the nation.

Related Findings From the Professional Stakeholder Survey, the Focus Group Survey, and Focus Group Participants

Immunization was a highly important performance measure to our sample of MCH professionals; 76% agreed that a full schedule of age appropriate immunizations for young children is highly important to their communities or regions. On the other hand, only 54% felt that this issue would be important to a significant number of their clients.

Of the 117 focus group participants, 56% have received routine immunizations for their children, and 40% have received child immunization education. In half of our focus group meetings, participants affirmed that the ability to procure appropriate immunizations was highly important to them and to their communities.

NPM #8. The Rate of Birth (per 1,000) for Teenagers Aged 15-17 Years

The HP 2010 target rate is 43 per 1,000 births. Data from HP 2010 and Critical Health Objectives for Adolescents and Young Adults indicate that, between 1996 and 2002, teenage birth rates for both Tennessee and the U.S. plummeted. In 1993, Tennessee' s adolescent birth rate was 39 per 1,000 for young women aged 15-17 years. By 2002, the rate decreased to 30 per 1,000 births, a decrease of 23%. For the U.S., the birth rate for this age group dropped 24%, from 33 per 1,000 births in 1996 to 29 per 1,000 in 2002. Both Tennessee and the U.S. have surpassed the HP2010 target rate of 43 births per 1,000. The teenage birth rate for Tennessee remains much higher than that for the nation.

For Tennessee women aged 10-17 years, a 37% decrease in the birth rate (per 1,000) was observed between 1993 and 2002. During this period, African Americans in this age cohort experienced a 44% decrease in birth rate. The corresponding decline among non-Hispanic whites was 36%.

Related Findings From the Professional Stakeholder Survey and the Focus Group Survey

The importance of this issue for the 169 professional stakeholders is evidenced by the fact that 73% agreed that the teenage pregnancy rate is highly important to their communities or regions. However, only 39% felt that this issue would be considered highly important to a significant number of their clients.

This is in contrast to the degree of interest in family planning and pregnancy issues discussed at focus group meetings. Only affordable health insurance was identified as a high priority more often than family planning services, both for focus group participants and their communities. A significant percentage of our participants had obtained adolescent sexuality services such as contraceptive supplies (20%), parenting education (22%), and pregnancy prevention program (16%).

"…we need to start in the home because a lot of parents don' t want to talk to their kids about sex and telling them what sex is and what sort of things that are going on because they are afraid that if they tell the kids what's really going on then their kids are going to go out and do it. When if you are telling your kids the truth then they are more likely not to do it and more likely to stay away from it. My parents never taught me about sex." Johnson City focus group participant

"We need a male role model, somebody who will talk to our [young] men." Brownsville focus group participant

NPM #9. Percentage of Third Grade Children Who Have Received Protective Sealants on at Least One Permanent Molar Tooth

The HP 2010 goal for this NPM is 70%. According to the National Center for Chronic Disease Prevention and Health Promotion, 40,788 of Tennessee's children received dental sealants in 2004. In a personal communication, Dr. Suzanne Hubbard, Director of Oral Health Services for TDH, asserted that, of 745 eligible K-8 schools, students in 381 of these received dental screenings in 2004. In order for a school to be eligible for this program 50% or more of its student population must be entitled to receive either free or reduced-priced lunches. The K-8 students in 328 eligible schools received full, comprehensive preventive dental services. Each student in these 328 schools was provided with a parental consent form that authorized the TDH to provide the child with a protective dental sealant. Approximately 50% of the children returned signed parental consent forms. Of these, 70% received protective dental sealants. The decision to provide, or not to provide, a protective sealant is made by the dentist.

"They've got a really great dental program here, I think that it's great how they go into the schools and then also how they do dental work and dental screenings." Johnson City focus group participant

Information on the percentage of Tennessee's third grade students receiving dental screening in 1997 comes from Brumley and Gillcrist (1999). These authors present survey data suggesting that 22% of eight-year-old children in Tennessee received protective dental sealants in 1997. The HP 2000 goal for third graders was 50%.

Related findings from the Professional Stakeholder Survey, the Focus Group Survey. and Focus Group Meetings

Seventy percent of our MCH professional stakeholders said that child dental care was highly important to their communities or regions; only 46% thought that this issue would be highly important to a significant number of their clients.

The issue of dental care did arise at focus group meetings. However, parents primarily voiced frustration at the lack of resources devoted to adult care. TennCare provides dental care resources for children, but not to adult clients. This reality was seen as posing financial hardship on families who qualify for TennCare.

Clearly, dental screening and the application of protective sealants is an issue on which Tennessee could show improvement. Strategies must be developed to increase the number of schools participating in dental screening programs, and to increase the percentage of parents willing to sign consent forms related to the procurement of dental sealants for their children.

NPM #10. The Rate of Deaths to Children Aged 14 Years and Younger Caused by Motor Vehicle Crashes per 100,000 Children

Table 2 summarizes state and national motor vehicle crash induced death rates per 100,000 for children aged 14 years and younger. According to a tip sheet developed by the East Tennessee Children's Hospital called, "Tennessee Child Passenger Safety Law," Tennessee's child fatality rate in car crashes is 50% higher than that of the nation. In 2000, the U.S. rate was 4.3, as compared to the Tennessee rate of 6.0. In 2002, the death rates had declined 3.9 for the U.S. and 5.3 for Tennessee. Although reductions have occurred in Tennessee's child death rates due to vehicular crashes between 2000 and 2003, the Tennessee rate remains well above

the national average. It should be noted that the 2003 rate shown for Tennessee in Table 2 is an estimate that has not yet been verified.

Table 2. Death Rates (Per 100,000) for Children Aged 14 Years and Younger Caused by Motor Vehicle Crashes – Tennessee and the U.S.*

Year	Tennessee (Rate per 100,000)	U.S. (Rate per 100,000)
2003	4.5**	N/A
2002	5.3	3.9
2001	5.0	4.1
2000	6.0	4.3

* Office of Statistics and Programming, National Center for Injury Prevention and Control.
** 2003 Estimation: Death Certificate Data (Tennessee Resident Data) Tennessee Department of Health.

These findings are also in line with youth deaths associated with motor vehicle crashes. In 2001, the rate of deaths to Tennessee youth (ages 15-24) caused by motor vehicle crashes was 42 per 100,000. The corresponding national rate, in 1999, was 26 per 100,000. Thus, Tennessee has a great deal of work to do in bringing its motor vehicular death rates in line with those of the nation.

Related Findings From the Professional Stakeholder Survey and Focus Group Survey

The Professional Stakeholder Survey did not include a question that specifically addressed this issue. However, the survey did address child and youth deaths generically. Of the 169 survey respondents, 58% indicated that child and youth death rates constituted a highly important issue for their communities or regions; only 27% felt that this issue was highly important to their clients.

Findings from the Focus Group Survey indicated that 13% of our focus group respondents had participated in injury prevention and safety education.

NPM #11. Percentage of Mothers Who Breastfeed Their Infants at Hospital Discharge

In 2002, the Ross Laboratories National Survey indicated that:

- 70% of U.S. infants and 61% of Tennessee infants were breastfeeding upon hospital discharge.
- At six months, only 33% nationally and 23% in Tennessee were still breastfeeding their babies.

Among WIC mothers in 2002:

- 59% of mothers nationally and 48% of Tennessee mothers were breastfeeding their infants upon hospital discharge.
- At six months, only 22% nationally and 14% in Tennessee were still breastfeeding their babies.

The HP2010 target rate is 75% breastfeeding at hospital discharge and 50% breastfeeding at 6 months. Both Tennessee and the U.S. have a great deal of work to do to improve performance on this measure.

Healthy People 2010 provides national data by race/ethnicity but we could not find these data for Tennessee. National breastfeeding rates in 2004 were as follows:

African American – 54% at hospital discharge; 19% at six months
Hispanic – 71% at hospital discharge; 33% at six months
Non-Hispanic white – 73% at hospital discharge; 36% at six months

Related Findings From the Professional Stakeholder Survey and Focus Group Survey
Relatively speaking, this issue was not highly important for the 169 MCH professionals responding the Stakeholder Survey. Only 44% felt that breastfeeding rates were highly important to their communities or regions; and only 29% felt that this issue was highly important to a significant number of their clients. This finding is interesting because it has been well established that breastfeeding gives babies a better start in life than does formula feeding. It builds up immunities in babies, promotes better mother-child bonding, and is especially important nutritionally to low birth weight infants. Nevertheless, less than half of our Professional Stakeholder Survey respondents saw breastfeeding as highly salient to their communities and/or regions.

However, a perhaps surprising percentage – 41% – of our Focus Group participants actually received breastfeeding information from state-supported MCH services and several focus group participants discussed its being important to them.

"And the lady at the WIC department she looked at me and she said, 'do you mean that you're still nursing this other child?' and she was very abrupt and she thought that I should just quit right then and I said, 'well everything that I've learned and read about it said that it's supply and demand and my body if fully capable of doing it. And I eat well', and I didn't see anything wrong with it…but she scolded me pretty good." Jackson focus group participant

NPM #12. Percentage of Newborns Who Have Been Screened for Hearing Upon Hospital Discharge
The National Center for Hearing Assessment & Management asserts that, as of January 2004, 90% of Tennessee's newborns were screened for hearing. According to the World Council on Hearing Health, this 90% figure equals that for the nation. This finding represents a 65% increase nationally over the past five years. In fact, in 1999, only 25% of U.S. newborns were screened for hearing loss or function.

Related Findings From the Professional Stakeholder Survey and Focus Group Survey
As noted for the first National Performance Measure, 77% of respondents to the Stakeholder Survey agreed that newborn screening, including hearing screening, constitutes an issue that is highly important to their communities or region; 46% felt that newborn screening would be highly important to a significant number of clients as well.

NPM #13. Percentage of Children Without Health Insurance
The U.S. MCH Bureau's American Academy of Pediatrics estimates that in 2001:

- 7% of Tennessee's children were uninsured; the corresponding percentage for the nation is 12%. Perhaps because of TennCare, the state's percentage of uninsured children compares quite favorably to that of the nation.
- 30% of Tennessee's children are enrolled in the Medicaid/SCHIP (TennCare) program; the national Medicaid/SCHIP enrollee percentage is 21%.
- 64% of Tennessee children have private or employer-based insurance, compared with 68% for the U.S.

NPM #14. Percentage of Potentially Medicaid-Eligible Children Who Have Received a Service Paid by the Medicaid Program

According to Kids Count (2002), 100% of all persons determined eligible for TennCare Medicaid are served by this program. Eligible children include:

- Children receiving Families First cash assistance
- Temporary Assistance to Needy Families
- Children whose families meet the "Poverty Level Income Standard"
- Children receiving Special Supplemental Security Income

In 2001, 45% of all TennCare enrollees were children. The change from Medicaid to TennCare resulted in improved care for Tennessee's children from low income families. For example in 2001, only 9% of children enrolled in TennCare saw a physician " only rarely," down from 15% under Medicaid in 1993. Tennessee's 8% rate of uninsured children was the lowest in the nation in 2002.

Related Findings From the Focus Group Survey and Focus Group meetings

Sixty percent of focus group members were enrolled in TennCare. Nearly all focus group participants reported that TennCare and/or affordable health care was a high priority for both their families and their communities.

Although TennCare is under strain and litigation, the percentage of children insured under this program should not be affected. For Tennessee's children, TennCare should remain one of the strongest public health care insurance programs in the U.S.

NPM #15. Percentage of Very Low Birth Weight (<1500 Grams Or <3.31 Pounds) Infants Among All Live Births

According to the Tennessee Department of Health, of the 78,871 live births in 2003, 2% could be characterized as "very low" birth weight (VLBW) infants. Of the state's 60,630 non-Hispanic white live births, 1% were VLBW babies. The percentage of VLBW babies among Tennessee's 16,160 African-American live births in 2003 was 3%. The HP2010 target percentage is 0.9%.

Table 3 shows comparative Tennessee and U.S. percentages of VLBW infants by racial/ethnic category for 1998 and 2002. Tennessee' s VLBW percentages are not strikingly different from those of the nation as a whole.

Table 3. Percentages of Very Low Birth Weight (VLBW) Infants by Race/Ethnicity for Tennessee and the U.S. in 1998 and 2002

Race/Ethnicity	1998 TN	2002 TN	1998 U.S.	2002 U.S.
African American	3.3	3.3	3.1	3.1
Hispanic	1.0 *	0.6	1.1	1.2
Non-Hispanic White	1.2	1.3	1.1	1.2

*Data from 1999

The Tennessee percentage of VLBW births for male infants slightly exceeded that for female infants. This finding also existed for the U.S. in 1998, but not in 2002 (see Table 4).

Table 4. Percentages of Very Low Birth Weight (VLBW) Infants by Sex for Tennessee and the U.S. in 1998 and 2002

Sex of Infant	Tennessee % VLBW Infants		U.S. % VLBW Infants	
	1998	2002	1998	2002
Female	1.8	1.7	1.4	1.5
Male	1.6	1.8	1.5	1.5

To summarize, with the exception of Hispanics, Tennessee' s percentage of VLBW infants tends to be slightly higher than that for the nation as a whole. This trend holds true for African American and non-Hispanic white infants and for female and male infants as well.

Related Findings From the Professional Stakeholder Survey

Sixty-nine percent of the 169 Professional Stakeholder Survey respondents agreed that the VLBW infant issue was highly important to their communities or regions; 41% also felt that this issue was highly important to a significant number of their clients.

NPM #16. Rate (Per 100,000) of Suicide Deaths Among Youth Aged 15 Through 19

Tennessee's 2001 suicide rate for adolescents aged 15-19 (per 100,000) was approximately one percentage point higher than that for the United States. According to the National Adolescent Health Information Center, the suicide rate was 9 per 100,000 among 15-19 year olds; the corresponding rate for the U.S. was 8 per 100,000.

When Tennessee's youth death rates from accidents, homicides and suicides are combined, the rates are clearly higher than those for the nation.

Tennessee lost 80 teens per every 100,000 to one of these three causes of death in 1996; the corresponding national rate was 60 per 100,000. By 2001, youth death rates were significantly reduced for both Tennessee – 65 per 100,000 and the nation – 50 per 100,000. Tennessee's rates have decreased but more improvement is needed.

Other related data, gleaned from the TDH, Office of Policy, Planning and Assessment, Division of Health Statistics indicates the following:

- Tennessee's African American teen (ages 10-19) suicide rate was 0.6 in 2003, down from 3.7 in 2000.
- Tennessee's non-Hispanic white teen suicide rate was 4.8 in 2003, down from 6.6 in 2000.

NPM #17. Percentage of Very Low Birth Weight (VLBW) Infants Delivered at Facilities for High-Risk Deliveries and Neonates

Table 5 shows the percentage of VLBW infants, by racial classification, delivered at Level III hospitals in Tennessee from 1999 through 2003. According to Tennessee data, 80% of Tennessee's VLBW infants were delivered at Level III hospitals in 1999. This percentage declined and then stabilized at around 74% beginning in 2001. Tennessee's 2003 target

percentage was 80%. Even with this overall percentage decline in VLBW infants delivered in Tennessee's Level III hospitals, the state's performance on this issue is similar to that of the U.S. as a whole.

According to HP2010, 73% of the Nation's very low birth weight infants were delivered at Level III hospitals or subspecialty perinatal centers during 1996-1997; the HP2010 target for this performance measure is 90%.

Breaking down these percentages by race, African American VLBW infants are significantly more likely than are their non-Hispanic white counterparts to have been born in Level III hospitals. For example, in 2002, 77% of the state's African-American VLBW infants were delivered at Level III hospitals; the non-Hispanic white percentage was 71%. Nevertheless, the percentage of VLBW infants delivered at Level III hospitals has significantly declined for both racial groupings, and Tennessee's performance on this issue needs to be improved.

Table 5. Percentage of VLBW Infants Delivered at Level III Hospitals in Tennessee by Year and Racial Classification*

Race/Ethnicity	1999 %	2000 %	2001 %	2002 %	2003 %
African American	85.1	82.5	75.7	77.2	N/A
Non-Hispanic White	76.4	75.1	73.9	70.9	N/A
Total	79.7	78.0	74.5	73.9	74.8

* 1999-2002 data: http://www.schsr.unc.edu/data/Rndmu/TablesE.xls.
2003 data: https://performance.hrsa.gov/mchb/mchreports/Search/core/coresch01p_result.asp

NPM #18. Percentage of Infants Born to Pregnant Women Receiving Prenatal Care Beginning in the First Trimester

Martin et al. (2003) assert that 82% of Tennessee mothers began prenatal care during the first trimester. The national rate in 2002 was 84%. The HP2010 target is 90%.

Broken down by race/ethnicity Tennessee's "prenatal care beginning first trimester" percentage lagged the nation's in 2002; this difference was especially pronounced for Tennessee's Hispanic population (see Table 6).

Table 6. Percentage of Infants Born in 2002 to Pregnant Women Receiving Prenatal Care Beginning in First Trimester by Race/Ethnicity

Race/Ethnicity	Tennessee %	U.S. %
African American	72	75

Hispanic	59	77
Non-Hispanic White	86	85
Total	83	84

Other findings regarding the adequacy of prenatal care are summarized as follows:

- Between 1998 and 2002, the percentages of pregnant women beginning prenatal care during the first trimester did not meaningfully improve for either Tennessee or for the nation.
- Tennessee's overall percentage for pregnant women who began prenatal care during the first trimester was 1% higher than the nation's in 1998 but 1% lower in 2002.
- In Tennessee, the percentage of Hispanic women receiving first trimester prenatal care actually declined 6%, from 65% in 1998 to 59% in 2002.

A similar pattern appeared in the "Percent of Live Births by Adequacy of Prenatal Care" in Tennessee between 1998 and 2002 report. This measure was obtained with the Kessner Index which classifies prenatal care by prenatal visits, gestational age, and when trimester care began. Findings can be summarized as follows:

- Only 74% of Tennessee women were judged to have received " adequate" prenatal care in 2002, down from 77% in 1998.
- In 2002, 8% of Tennessee women received inadequate or no prenatal care, up from almost 7% in 1998.

Related Findings From the Professional Stakeholder Survey, the Focus Group Survey, and Focus Group participants

Seventy-five percent of Professional Stakeholder Participants felt that early and adequate prenatal care was highly important to their communities or regions but only 48% agreed that a significant number of their clients would consider this issue highly important. In actuality, 51% of focus group participants took advantage of prenatal care services during their first trimester of pregnancy; 33% participated in educational classes concerning the prevention of premature births. In more than half of the focus group meetings, participants identified good prenatal care as a priority for themselves and their families.

2000 TENNESSEE PERFORMANCE MEASURES (TPMS) – ANALYSIS AND RESULTS

As was the case with the MCH National Performance Measures, relevant state and national data are summarized, including data from HP2010. Where relevant, data obtained from the Professional Stakeholder Survey, Focus Group Survey, and focus group meetings will be included.

In 2000, the Tennessee Department of Health identified eight performance measures that the state would address during the subsequent five-year period. Outcomes related to these performance measures constitute a crucial element of TDH-MCH's future planning process. The Tennessee performance measure outcomes are especially relevant to TDH-MCH as it develops new Tennessee MCH performance measures to be addressed during 2005-2010.

TPM #1. After Implementation of Folic Acid Education at State, Regional, and Local Levels, Reduce the Number of Neural Tube Defects Births

Between 2000 and 2002:

- Tennessee experienced 25 cases of Anencephaly; a rate of 1 per 10,000 births; this rate equaled that of the nation.
- 74 cases of Spina Bifida were diagnosed in Tennessee during this time period, a rate of 3 per 10,000 births as compared with 2 per 10,000 in the U.S.
- 26 cases (1 case per 10,000) of Encephalocele occurred in Tennessee between 2000 and 2002.

The HP2010 target rate for neural tube defects is 3 per 10,000 births.

Related Findings From the Professional Stakeholder and Focus Group Survey

This issue was moderately important to MCH professionals who responded to the Professional Stakeholder Survey; 43% agreed that the existence of neural tube defects among infants constituted a highly important issue for their communities or regions; 34% felt the issue would be considered highly important by a significant number of their clients. Among focus group participants, 37% received educational programs focusing on the importance of folic acid in the diets of pregnant women.

TPM #2. Reduce to No More Than 4% Elevated Blood Lead Levels in Children 6-72 Months of Age Who are Screened

Tennessee appears to be achieving this objective. Screenings conducted during 2001 and 2002 found that only 1% of Tennessee's children had elevated blood levels; the percentage of children with elevated blood levels for the nation as a whole was 3% in 2001.

Related Findings From the Professional Stakeholder Survey and the Focus Group Survey

Forty-six percent of the 169 MCH professionals felt that addressing elevated blood lead levels in children was of high importance to their communities or regions but only 30% agreed that this issue would be highly important to a significant number of their clients. Approximately 29% of the 117 focus group participants received lead poisoning education and another 8% had their homes inspected for lead.

TPM #3. Reduce the Percentage of High School Students Using Tobacco (Cigarettes and Smokeless)

Data suggest some degree for optimism for a downward trend in tobacco use among Tennessee's high school student population. According to Tennessee's Youth Risk Behavior Surveys for 1999 and 2003:

- Each tobacco use indicator showed a marked decrease in percentage of use over this five-year period. This downward trend also exists for the nation.
- The percentage of Tennessee's high school student population smoking one or more cigarettes during the 30 day period prior to interview, decreased from 38% in 1999 to 28% in 2003.
- The percentage of high school students who had smoked at least one cigarette 20 or more days of that 30 day period decreased from 20% in 1999 to 15% in 2003.
- The percentages of high school students reporting that they "ever smoked daily" decreased from 28% in 1999 to 20% in 2003.
- Use of smokeless tobacco also decreased, but only slightly.

While state rates have declined, Tennessee's high school student tobacco use percentages still lead the nation as a whole by 5% on each of the above-listed indicators. However, in 2003, 5% of Tennessee's high school students reported smoking "10 or more cigarettes on days they smoke." For this indicator, Tennessee high school students were quite close to their counterparts across the nation; the National percentage was 3%.

Related Findings From the Professional Stakeholder and Focus Group Survey

Utilization of tobacco and alcohol were included together as one of the 47 issues listed in the Professional Stakeholder Survey. Sixty-six percent of the stakeholders felt this issue was highly important to their communities or regions and 31% believed that a significant number of their clients would find youth tobacco and alcohol use highly important as well. Among our focus group participants, 10% had participated in a youth alcohol/tobacco/drug prevention program

TPM #4. Reduce the Percentage of High School Students Using Alcohol

According to the Youth Risk Behavior Survey, alcohol use among Tennessee' s high school students appears to be decreasing though not at the rate seen for tobacco.

- In 1999, 45% of Tennessee's high school students reported taking one or more drinks during the 30-day period prior to interview; by 2003 this percentage had decreased to 41%.
- In 1999, 28% of students reported taking five or more drinks at one time during the "last 30 days." By 2003, the rate had decreased by only two percentage points to 26%.
- On a brighter note, Tennessee high school students' alcohol use tended to be slightly lower than the nation's.
- In 2003, 41% of Tennessee students and 45% of U.S. students reported drinking one or more drinks during the "last 30 days."
- In 2003, 26% of Tennessee students and 28% of U.S. students reported drinking five or more drinks at one time during the last 30 days.

TPM #5. Reduce the Incidence of Maltreatment of Children Younger than 18 (Physical, Sexual, Emotional Abuse, And Neglect) to a Rate No More than 8 Per 1,000

According to Kids Count data, Tennessee has met, and even exceeded, its target rate. In 1999, Tennessee's abuse and neglect rate was 8 per 1,000 children; by 2003 the rate declined to 4 per 1,000. By comparison, the U.S. rate in both 1999 and 2003 was 12 per 1,000.

Reporting validity is always open to question on this highly charged issue. However, keeping this caveat in mind, Tennessee's rate of abuse and neglect has consistently outperformed the nation as a whole.

Related Findings From the Professional Stakeholder and Focus Group Survey

The maltreatment of children represented a salient issue to our professional stakeholders, with 71% indicating that maltreatment of children constituted an issue that was highly important to their communities or regions; 38% felt that this issue would be highly important to a significant number of their clients as well. According to focus group survey findings, 7% of the 117 participants had participated in child abuse counseling.

TPM #6. Reduce the Number of HIV Infected Infants to No More Than One Per Year

TDH-MCH has not achieved this objective. In 1999, 3 HIV infected infants were born in Tennessee. In 2003, 5 infants were infected with HIV.

Related Findings From the Professional Stakeholder and Focus Group Survey

Of Professional Stakeholder Survey respondents, 55% viewed this issue as highly important to their communities or regions; 30% felt that the problem of HIV-infected infants would also be highly important to a significant number of their clients. Three percent of the 117 Focus Group participants had taken part in a program regarding care for HIV-infected infants.

TPM #7. Increase the Percentage of Children With Complete Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Annual Examinations by 3% Each Year.

EPSDT is Medicaid's comprehensive and preventive child health program for individuals under 21 years of age. This periodic screening includes vision, dental, and hearing services, whether or not such services are included as part of a state's Medicaid plan. According to Centers for Medicare & Medicaid Services (CMS), the EPSDT program has two interrelated components: (1) assuring the availability and accessibility of required health care resources; and (2) helping Medicaid recipients and their parents or guardians effectively use these resources.

In 1999, 271,845 total EPSDT screenings were completed according to Tennessee's CMS annual report for that year. Based on CMS-EPSDT program eligibility requirements, a screening ratio of 0.36 (the proportion of all persons who are eligible for screening who have actually been screened) was obtained in 1999. For 2003, 374,918 total screenings were conducted, representing a screening ratio of 0.57. Thus, Tennessee is meeting its target goal of at least 3% annual increases in the CMS screening ratio over the past five-year period.

Related Findings From the Professional Stakeholder and Focus Group Survey

Of Professional Stakeholder Survey respondents, 73% felt that EPSDT screening of children was highly important to their communities or regions; 53% said that this issue would be important to a significant number of their clients as well. The availability of annual examinations was indeed important to a number of the 117 focus group participants.

52% received newborn screening for infant hearing/genetic/medical problems
15% received diagnostic testing for at least one child
39% received dental exams and cleaning
32% received eye exams and services

TPM #8. Reduce the Proportion of Teens and Young Adults (Ages 15-24) with Chlamydia Trachomatis Infections Attending Family Planning Clinics

According to the STD Surveillance System's Chlamydia Screening Project, Tennessee's Family Planning clinics have not experienced a reduction in the percentage of teen clients with Chlamydia Trachomatis. During 2003, 7% of teens were treated for Chlamydia, up from 5% for both 1999 and 2002. Nevertheless, Tennessee's percentages for this disease are almost identical to those of the nation. For the 3 years in question, the corresponding U.S. percentage has remained at 6%.

Related Findings From the Professional Stakeholder and Focus Group Surveys, and From Focus Group Meetings

Sexually transmitted diseases among youth was considered a highly important issue for 59% of MCH professionals; 37% also felt that a significant number of their clients would consider this a highly important issue.

Focus Group participants participated in the following adolescent sexuality education and family planning services:

27% annual gynecological exam

20% family planning/contraception information
20% reception of contraceptive supplies
16% pregnancy prevention program
13% education/testing/treatment for sexually transmitted illnesses
9% sexual abstinence education
7% HIV/AIDS prevention, testing or treatment

In more than half of the focus group meetings, family planning, pregnancy and STD prevention were cited by participants as important to the participants themselves, as well as to the communities in which they lived.

Thus, although TDH-MCH has not met its TPM #8 objective, the state is actively pursuing the reduction of sexually transmitted diseases among youth. And, among the TDH-MCH clients attending focus group meetings, a sizable number see these issues as highly important. In fact, a sizable number are taking advantage of these programs and services.

THE PROFESSIONAL STAKEHOLDER SURVEY – ANALYSIS AND RESULTS

This section will present the data from the professional stakeholder survey. Please see Appendix C for complete details including a copy of the survey and the complete presentation, expanded from the April 22, 2005 meeting presentation. The survey addressed four opinion-topics related to each of the 47 issues presented in the survey as follows:

Opinion Topic #1. Does the professional consider the issue to be "highly important" to her/his agency's community or region?

Opinion Topic #2. Does the professional consider the issue to be "highly important" to a significant number of her/his clients?

Opinion Topic #3. Does the professional feel that her/his agency " does a good job" in addressing the issue in question?

Opinion Topic #4. If the professional's agency does not address the issue in question, does s/he feel that the agency should address this issue?

Opinion Topic #1

At the end of the questionnaire's list of 47 MCH issues, each respondent was asked to answer the following question: "Of these 47 issues, which three are the MOST IMPORTANT to your COMMUNITY/REGION?" Of the 169 professional respondents, 160 or 95% answered this question.

Little agreement could be found among the 160 professionals as to which MCH issues should be considered the "three most important" to their communities or regions. However, eight issues received at least 4% of the professionals' first, second, and third choices (grouped together).

Newborn screening and follow-up for infant hearing and serious genetic or medical conditions
Infant mortality rate
Early and adequate prenatal care
Teenage pregnancy rate

Children without medical insurance
Child physical, sexual, and emotional abuse
Early, periodic, screening, diagnosis & treatment (EPSDT), and annual exams for all children in need
Nutrition/obesity among children, youth, and families

Another way of assessing the salience of these issues to the 169 MCH professionals who took part in our survey was to look at each of the 47 issues individually. Twenty of these issues received high (60% or higher) endorsement by the overall sample. In fact, 9 of the 47 MCH issues were considered by at least 70% of the 169 MCH professionals to be highly important to his/her community or region.

Children without medical insurance (79%)
Newborn screening and follow-up for infant hearing and serious genetic or medical conditions (77%)
Young children receive full schedule of age appropriate immunizations (76%)
Early and adequate prenatal care (75%)
EPSDT annual exams for all children in need (73%)
Teenage pregnancy rate (73%)
Alcohol and drug use among pregnant women (71%)
Maltreatment of children (physical, sexual, and emotional abuse) (71%)
Dental care for children (70%)

An additional 11 MCH issues were considered to be highly important to their communities or regions by between 60% and 69% of the 169 MCH professionals:

Low and very low birth weight infants (69%)
Unintended pregnancy-women of all ages (68%)
Nutrition & obesity among children, youth, and families (68%)
Infant mortality rate (66%)
Tobacco use among pregnant women (66%)
Tobacco, alcohol, and drug use among youth (66%)
Preterm birth rate (<37 weeks gestation) (64%)
Language issues and access to translation services (63%)
Pregnant women or children exposed to second hand smoke (62%)
Consistent, stable place to live or shelter (62%)
Physical activity and fitness for children, youth, and families (60%)

Interestingly, none of the issues relating to families of children with special health care needs was endorsed by 60% or more of the professional respondents as being highly important to their communities or regions. This finding is perhaps an artifact of the relatively low percentage of CSHCN families in any community, or perhaps a relatively low number of the MCH professionals who responded to the survey worked with a high percentage of SCHCN clients.

<u>Regional and Rural vs. Urban Response Variations for Opinion Topic #1</u>
Simple Chi-Squared tests were run between the regional location of the professional stakeholder 's agency and each of the 47 MCH issues listed in the Professional Stakeholder Survey. The same type of analysis was conducted for rural vs. urban agency location as well. Statistically significant regional differences were found in response pattern for 12 of the 47 MCH issues; for 6 MCH issues, statistically significant differences in response pattern were found for

rural and urban professionals. A detailed analysis of these differences can be found in Appendix C.

Opinion Topic #2

For Opinion Topic #2, respondents were asked, "Which three . . . [of the 47 issues cited in the Survey] … do you think are the MOST IMPORTANT to a significant number of your CLIENTS?" Again, comparatively little agreement existed among the 153 or 91% professionals who responded to this question. However, seven issues did receive at least 4% of first, second, and third choices (grouped together) as highly important to a significant number of agency clients.

Early and adequate prenatal care
Unintended pregnancy-women of all ages
Children without medical insurance
Families of CSHCN have adequate private or public insurance to pay for needed services
Transportation issues and proximity to services
Language issues and access to translation services
Consistent, stable place to live or shelter

It should be noted that only two of these issues (**children without medical insurance**, and **early and adequate prenatal care**) were endorsed by at least 4% of professional stakeholders as "the three most important" for their **communities or regions** (Opinion Topic #1).

These differences in issue selection may demonstrate that the agency professionals who responded to the Professional Stakeholder Survey are in tune with their clients. It makes sense, for example, that clients would view transportation and language issues as important to a greater degree than would agency professionals. The same is true for the issue, "consistent, stable place to live or shelter." Unintended pregnancy may constitute another intense area of concern for MCH agency clients, and their children as well.

As we did for Opinion Topic #1, we looked at the responses of the 169 Professional Stakeholder Survey participants to each individual MCH item. A similar analysis for Opinion Topic #1 showed that nine of the 47 MCH issues received endorsement from at least 70% of the MCH professionals. However, for Opinion Topic #2, no issue received endorsement from more than 62% of the respondent sample. Thus, the agency professionals who responded to our survey share relatively low agreement about this aspect of their clients' perceptions.

Of the 47 MCH issues, 6 were thought by the 169 professional stakeholders to be "highly important to a significant number of their clients."

Children without medical insurance (62%)
Language issues and access to translation services (55%)
Young children receive full schedule of age appropriate immunizations (54%)
EPSDT annual exams for all children in need (53%)
Transportation issues and proximity to services (52%)
Consistent and stable place to live or shelter (50%)

An additional 17 MCH issues were endorsed by between 40% and 48% of the professional respondents, as being "highly important to clients."

Early and adequate prenatal care (48%)
Families of CSHCN partner in decision-making and are satisfied with services received

(48%)
Economic stability of the family (48%)
Families of CSHCN have adequate private or public insurance to pay for needed services (47%)
Dental care for children (46%)
Newborn screening and follow-up for infant hearing and serious genetic and medical conditions (46%)
Services available at varied times of day (46%)
CSHCN receive coordinated, ongoing, comprehensive care within a medical home (43%)
Unintended pregnancy for women of all ages (43%)
Families of CSHCN report community-based services organized and can be used easily (43%)
Nutrition and obesity among children, youth, and families (42%)
Low and very low birth weight babies (41%)
Tobacco use among pregnant women (41%)
Healthy, full term infants placed on their backs to sleep (40%)
Alcohol and drug use among pregnant women (40%)
Pregnant women and children exposed to second hand smoke (40%)
Occurrence of developmental disabilities among children (40%)

Not surprisingly, the 7 items that were considered by 4% or more of our professional respondents to be one of the three most important MCH issues for a significant number of their clients also appear on the subsequent lists of MCH issues. Of these 7 issues, only 4 were endorsed by 50% or more of our professional respondents when analyzed individually:

Children without medical insurance (62%)
Language issues and access to translation services (55%)
Transportation issues and proximity to services (52%)
Consistent, stable place to live or shelter (50%)
Early and adequate prenatal care (48%)
Families of CSHCN have adequate private or public insurance to pay for needed services (47%)
Unintended pregnancy for women of all ages (43%)

Regional and Rural vs. Urban Response Variations for Opinion Topic #2

Marked regional differences were found for 17 of the 47 MCH issues regarding the extent to which professional stakeholders felt that these issues held high salience for a significant number of their clients. However, only one issue achieved statistical significance for the rural vs. urban response pattern. These regional and rural vs. urban response patterns for Opinion Topic #2 are presented in Appendix C.

Table 7 below presents the complete list of the 47 MCH issues and the percentage of respondents who agreed that the issue was highly important to their community or region and highly important to a significant number of their clients.

Table 7. Percentage of Professionals Agreeing that Issue is "Highly Important" to Community or Region and to a Significant Number of Their Clients (N = 169)

Issue	% "Highly Important to Community or Region"	% "Highly Important to a Significant Number of their Clients"
Newborn screening and follow-up for infant hearing and serious genetic/medical conditions	77	46
Breastfeeding rates	44	29
Infant mortality rates	66	37
Low and very low birth weight babies	69	41
Early and adequate prenatal care	75	48
Neural tube defects among infants	43	34
HIV-infected infants	55	30
Unintended pregnancy – women all ages	68	43
Health spacing of pregnancy	41	32
Maternal death due to pregnancy complications	43	26
Maternal illness due to pregnancy complications	41	29
Attendance by pregnant women and partners in childbirth education series	38	30
Rate of cesarean births for low risk women	31	21
Preterm birth rates (<37 weeks gestation)	64	41
Appropriate weight gain among pregnant women during their pregnancies	42	38
Healthy, full term infants placed on backs to sleep	57	40
Tobacco use among pregnant women	66	41
Alcohol/drug use among pregnant women	71	40
Fetal alcohol syndrome	53	35
Pregnant women/children exposed to second hand smoke	62	40
Young children receive full schedule of age appropriate immunizations	76	54
Teenage pregnancy rate	73	39
Dental care for children	70	46
Child and youth death rates	58	27
Adolescent deaths due to suicide	52	28
Children without medical insurance	79	62
Children with elevated blood lead levels	46	30
Tobacco, alcohol, drug use among youth	66	31
Maltreatment of children (physical, sexual, and emotional abuse)	71	38

EPSDT* annual exams for all children in need	73	53
Sexually transmitted diseases among youth	59	37
Occurrence of developmental disabilities among children	59	40
Families of CSHCN** partner in decision-making and satisfied with services received among children	47	48
CSHCN receive coordinated, ongoing, comprehensive care within medical home	47	43
Families of CSHCN have adequate private or public insurance to pay needed services	44	47
Families of CSHCN report community-based services organized, & can be used easily	41	43
Youth with special health care needs receive necessary services to make transition to all aspects of adult life	48	38
Transportation issues/proximity to services	53	52
Language issues/access translation services	63	55
Services available at varied times of day	50	46
Education level of parents	52	30
Education level: success of children/youth	54	37
Nutrition & obesity among children, youth, and families	68	42
Physical activity and fitness for children, youth, and families	60	36
Injury prevention and safety	54	34
Consistent, stable place to live/shelter	62	50
Economic stability of family	57	48

* Early, Periodic, Screening, Diagnosis & Treatment
** Children with Special Health Care Needs

Opinion Topic #3

In Opinion Topic #3, each professional was asked whether her/his agency "DOES A GOOD JOB" in addressing one or more of the 47 MCH issues. Responses to this question were considered only if the professional had indicated that her/his agency currently addresses the issue in question.

For only six issues did 70% or more of the relevant agency professionals say that their agencies "did a good job," as shown below:

(Survey #21). Young children receive full schedule of age appropriate immunizations (N = 132; 83%)
(Survey #16). Healthy full-term infants placed on their backs to sleep (N = 117; 74%)
(Survey #33). Families of CSHCN who partner in decision-making and are satisfied with services received (N = 99; 74%)

(Survey #34). CSHCN receive coordinated/ongoing/comprehensive care within a medical home (N = 89; 74%)
(Survey # 1). Newborn screening and follow-up for hearing/genetic and medical conditions (N = 113; 72%)
(Survey #30). Early, periodic screening/diagnosis/treatment/annual exams for all children in need (N = 130; 72%)

For an additional 18 MCH issues, between 50% and 69% of professional respondents gave their agencies a "good job" endorsement, as listed below:

(Survey #35). Families of CSHCN have adequate private or public insurance to pay for needed services (N = 83; 66%)
(Survey #2). Breastfeeding rates (N = 111; 63%)
(Survey #17). Tobacco use among pregnant women (N = 111; 63%)
(Survey #20). Pregnant women and children exposed to second-hand smoke (N = 94; 62%)
(Survey #31). Sexually transmitted diseases among youth (N = 93; 61%)
(Survey #5). Early and adequate prenatal care (N = 110; 61%)
(Survey #23). Dental care for children (N = 119; 60%)
(Survey #32). Occurrence of developmental disabilities among children (N = 105; 60%)
(Survey #36). Families of CSHCN report that community-based service systems are organized and easily accessed (N = 71; 58%)
(Survey #27). Children with elevated blood lead levels (N = 113; 56%)
(Survey #15). Appropriate weight gain among pregnant women (N = 83; 55%)
(Survey #39). Language issues and access to translation services (N = 119; 55%)
(Survey #40). Services available at varied times of day (N = 91; 55%)
(Survey #18). Alcohol/illicit drug use during pregnancy (N = 104; 54%)
(Survey #37). Youth with special health care needs receive services to make transition to all aspects of adult life (N = 73; 52%)
(Survey #42). Education level/success of children/youth (N 65; 52%)
(Survey #29). Physical/sexual/emotional abuse of children (N = 88; 50%)
(Survey #45). Injury prevention and safety (N = 98; 50%)

Thus, for 24 of the 47 MCH issues listed on the Professional Stakeholder Survey, at least 50% of pertinent agency professionals feel that their agencies "do a good job" in addressing the issue.

We now turn to MCH issues **for which less than 50% of relevant agency professionals** feel that their agencies "do a good job." This category represents a vital component of our MCH needs assessment research in that it is the professionals themselves who feel that their agencies should be doing a better job in addressing the issues listed below.

(Survey #6). Neural tube defects among infants (N = 76; 49%)
(Survey #19). Fetal alcohol syndrome (N = 67; 49%)
(Survey #38). Transportation issues and proximity to services (N = 65; 48%)
(Survey #46). Consistent and stable place to live or shelter (N = 66; 47%)
(Survey #4). Low/very low birth weight babies (N = 92; 47%)
(Survey #26). Children without medical insurance (N = 39; 46%)
(Survey #47). Economic stability of the family (N = 52; 46%)
(Survey #25). Adolescent deaths by suicide (N = 39; 46%)
(Survey #24). Child and youth death rates (N = 71; 46%)

(Survey #13). Rate of cesarean births for low risk women (N = 28; 46%)
(Survey #3). Infant mortality rate (N = 95; 45%)
(Survey #7). HIV-infected infants (N = 65; 45%)
(Survey #14). Preterm birth rate (before 37 weeks gestation) (N = 66; 45%)
(Survey # 28). Tobacco, alcohol, and drug use among youth (N = 70; 44%)
(Survey #9). Healthy spacing of pregnancies (N = 73; 44%)
(Survey #22). Teenage pregnancy rate (N = 93; 43%)
(Survey #43). Nutrition and obesity among children, youth, and families (113; 43%)
(Survey #80). Unintended pregnancy for women of all ages (N = 91; 43%)
(Survey #44). Physical activity and fitness for children, youth, and families (N = 72; 40%)
(Survey #11). Maternal illnesses from pregnancy complications (N = 56; 39%)
(Survey #12). Attendance in childbirth education series (pregnant women and partners) (N = 51; 39%)
(Survey #41). Education level of parents (64; 39%)
(Survey #10). Maternal deaths due to pregnancy complications (N = 43; 37%)

Less than half of the professionals whose agencies deal with these 23 MCH issues feel that their agency is "doing a good job" in attempting to ameliorate the problem area in question. We suggest that these issues, plus those in the above listing that garnered less than 60% of MCH professional endorsement, should be explored further for future MCH planning.

Opinion Topic #4

In order to garner information for Opinion Topic #4, each professional survey respondent was requested, for all 47 MCH issues, to "check Box (E) if your agency DOESN'T ADDRESS this issue BUT SHOULD." Perhaps not surprisingly, agency professionals appear to be relatively content with the current mission of their MCH agencies. Only for "maternal deaths due to pregnancy complications" and "adolescent deaths by suicide" did even 30% and 32% of relevant agency professionals suggest that their agencies take on these problems. Other issues garnering between 20% and 29% professional stakeholder endorsement in this regard are listed below, along with the N (representing number of professionals whose agencies DO NOT deal with this issue) and percentage (representing those professionals who feel that their agencies SHOULD DEAL with this issue):

(Survey #44). Physical activity and fitness for children, youth, and families (N = 97; 29%)
(Survey #12). Attendance in a childbirth education series (pregnant women and their partners) (N = 118; 25%)
(Survey #41). Education level of parents (N = 105; 25%)
(Survey #13). Rate of cesarean births for low risk women (N = 144; 24%)
(Survey #19). Fetal alcohol syndrome (N = 102; 24%)
(Survey #9). Healthy spacing of pregnancies (N = 96; 22%)
(Survey #39). Language issues and access to translation services (N = 50; 22%)
(Survey #40). Services available at varied times of day (N = 78; 22%)
(Survey #14). Preterm birth rate (before 37 weeks gestation) (N = 103; 20%)
(Survey #18). Alcohol and illicit drug use during pregnancy (N = 65; 20%)
(Survey #20). Pregnant women, children exposed to second hand smoke (N = 75; 20%)
(Survey #29). Physical/sexual/emotional abuse of children (N = 81; 20%)
(Survey #38). Transportation issues and proximity to services (N 78; 20%)

A number of professionals viewed the above-cited 15 MCH issues as so important that they should be addressed by their MCH agencies. Thus, these findings may be relevant to TDH-MCH's future planning.

THE FOCUS GROUP SURVEY – ANALYSIS AND RESULTS

As previously noted, 117 clients of TDH-MCH agencies participated in focus group sessions directed by the MTSU research team. These 13, 90-minute sessions were held at 12 locations in each major area of Tennessee. Attendance ranged from 5 to 16 participants, with an average of 10 participants per group. Of all participants, 42% were African American, 43% were non-Hispanic white, 11% were Hispanic, and 4% were classified as Asian or "other." Participants were overwhelmingly female (96%). Ages ranged from 18 to 56; the mean age was 30.

Prior to each meeting, participants were asked to sign an informed consent form and to complete the Focus Group Survey. Participants referred to their survey responses throughout the meeting.

After answering a number of demographic questions, participants were asked to "Check any of the following Maternal and Child Health Services you or your child have ever received." The 63 services were divided into "Women's Health," "Child and Adolescent Health," "Genetic and Newborn Screening," and "Adolescent Sexuality Education or Family Planning." The Women's Health category was further subdivided into " Family Planning," "Prenatal Care," and "Postnatal Care." Each category and subcategory of service listed contained an open-ended "other" response line in which the participants could add relevant MCH services to those not included in the questionnaire.

As noted earlier, all focus group participants were selected by professionals associated with agencies for which these meetings were held. Thus, the extent to which the participants utilized various services might be somewhat inflated in comparison with a participant pool selected by a more randomized selection procedure. Nevertheless, no sign of positive bias was encountered at focus group meetings. Participant comments ranged from laudatory to highly critical. The freedom with which participants expressed their opinions can be seen by reading complete meeting transcripts. Appendix D provides complete details of the focus groups, including the surveys and informed consent form, and the transcripts from all meetings.

Utilization of MCH Women's Health Services

Focus Group Survey findings will begin with "Women's Health." As noted above, this broad MCH category was subdivided into three sub-categories.

Family Planning Services

Of the six family planning services listed in the survey, three had been utilized by over 50% of focus group participants – medical examinations, pregnancy testing, and laboratory tests. Education and counseling for family planning was utilized by 38% of participants, and contraceptive supplies were obtained by 44%. Treatment for sexually transmitted illnesses was obtained by 7% of participants.

Prenatal Services

Nineteen services were listed under "Prenatal Services." Of these, five had been utilized by more than 50% of the focus group participants – pregnancy testing, TennCare enrollment, WIC referral or enrollment, nutrition education for pregnancy, and prenatal care during the first trimester of pregnancy.

Three services had been used by between 40% and 49% of the 117 participants – weight gain education during pregnancy, breastfeeding information, and education concerning the dangers of second hand smoke during pregnancy.

An additional five prenatal services had been utilized by between 30% and 39% of focus group participants – pregnancy and childbirth education classes, folic acid education for pregnancy, routine medical examinations by a physician, education concerning the prevention of premature birth, and parenting education. The complete list of services and the percentage of participants using them is listed below.

WIC referral or enrollment (80%)
TennCare enrollment (60%)
Pregnancy testing (56%)
Nutrition education for pregnancy (51%)
Prenatal care during first trimester (51%)
Education regarding the dangers of second smoke during pregnancy (43%)
Weight gain education during pregnancy (42%)
Breastfeeding information (41%)
Folic acid education for pregnancy (37%)
Pregnancy and birth education classes (37%)
Routine medical exams by a physician (37%)
Parenting education (35%)
Premature birth prevention education (33%)
Cesarean birth (29%)
Care for gestational diabetes, etc. (23%)
Alcohol and drug education for pregnant women (20%)
Obstetric medicine and management referral (20%)
Smoking cessation program for pregnant women who smoke (13%)
Routine medical exams by a midwife (8%)

Postnatal Services

Nine services were listed under postnatal services. Of these, only two (medical checkups for mother and medical checkups for newborn) had been utilized by more than 50% of focus group respondents.

Child immunization education was used by 40% of focus group participants, 34% received breastfeeding counseling, 27% received education on SIDS, and 28% received parenting education. The complete list of postnatal services is as follows:
Medical checkups for newborn (65%)
Medical checkups for mother (61%)
Child immunization education (40%)
Breastfeeding counseling and assistance (34%)
Parenting education (28%)
Sudden infant death syndrome (SIDS) education (27%)
Care for low birth-weight infant (17%)
Information regarding the healthy spacing of children (11%)
Care for HIV-infected infants (3%)

Utilization of Genetic and Newborn Screening Services

Four services were listed under this heading. Newborn screening for infant hearing/genetic/medical problems was utilized by 52% of focus group participants. No other service was utilized by more than 15% of the 117 focus group members.

Newborn screening for infant hearing/genetic/medical problems (52%)
Diagnostic testing (15%)
Other genetic screening (13%)
Counseling for individuals at risk for genetic disorders (8%)

Utilization of Child and Adolescent Health Services

Seventeen services were listed under this heading. TennCare enrollment and routine immunizations for children were utilized by more than 50% of focus group participants; flu shots for children was used by slightly over 40%. Three additional services were utilized by between 30% and 39% of participants – routine medical services, dental exams and cleanings, and eye examinations and related services.

TennCare enrollment (64%)
Routine immunizations for children (56%)
Flu shots for children (42%)
Dental exams and cleaning (39%)
Routine medical services (39%)
Eye exams and services (32%)
Lead poisoning: treatment and education (29%)
Children's Special Services (23%)
Healthy Start Program (20%)
Nutrition and obesity prevention and physical education (20%)
Parents Encouraging Parents (15%)
Injury prevention and safety education (13%)
Youth prevention program – tobacco, alcohol, and drugs (10%)
Childhood diabetes education and services (8%)
Home lead inspection and risk assessment (8%)
Counseling: sexual, physical, and/or emotional abuse (7%)
Child counseling: emotional and life transition problems (5%)

Utilization of Adolescent Sexuality Education and Family Planning Services

Eight services were listed under this category; none was used by more than 27% of focus group participants. Services receiving between 20% and 27% utilization were "family planning and contraception information," "annual gynecological examinations," "receiving contraceptive supplies," and "parenting education."

Annual gynecological examination (27%)
Parenting education (22%)
Contraceptive supplies (20%)
Family planning and contraception information (20%)
Pregnancy prevention program (16%)
Education, testing, and/or treatment of sexually transmitted illnesses (13%)
Abstinence education (9%)
HIV/AIDS prevention, testing or treatment (7%)

Problems Experienced by Focus Group Participants in Accessing MCH Services

After assessing MCH service utilization patterns among the 117 focus group participants, the survey instrument posed questions relating to potential problems that participants may have experienced in accessing MCH services. Table 8 summarizes the percentage of participants who have experienced one or more of these problem areas.

Table 8. Percentage of Focus Group Participants Who Experienced the Following Problems in Accessing MCH Services. (N = 117)

Access Problems Associated with Service	% Experiencing Problem
Transportation and location of services	15
Language barriers/access to translation services	10
Hispanic participants who report language barriers	69
Education and knowledge about services and how to get them	24
Insurance or ability to pay for services	34
Services available at varied times of day	13

Overall Satisfaction with Availability of MCH Services

Of the 117 focus group participants, 111 or 95% responded to the following question: "Overall, how would you rate the availability of services that you need?" Responses ranged from "very poor" to "very good" and are summarized in Table 9.

Table 9. "Overall, How Would You Rate the Availability of Services that You Need?" (N = 111)

Response Category	% Response
Very Good	35
Good	26
Average	33
Poor	5

Very Poor	1

The 111 participants who responded to this question appear to be relatively satisfied with the availability of MCH-related services in Tennessee. Sixty-one percent feel that service availability is at least "good," as opposed to the 6% who feel that service availability is poor. However, the 33% who rated the availability of MCH services as "average" suggest that improvements in overall MCH service availability could be made.

Overall Satisfaction with the Quality of MCH Services Received

The final question on the Focus Group survey form asked, "Overall, how would you rate the quality of services that you have received?" Responses to this question are summarized in Table 10.

Table 10. "Overall, How Would You Rate the Quality of Services that You Have Received?" (N = 112)

Response Category	% Response
Very High Quality	23
High Quality	36
Average Quality	38
Low Quality	3
Very Low Quality	0

None of the 112 respondents felt that MCH services were of "very low quality," and only 3% felt them to be of "low quality." On the other hand, 59%, believed MCH services to be of at least "high quality." Thus, participants appear to possess a favorable attitude towards state-provided MCH services. Nevertheless, the 38% of focus group participants who basically define state MCH services as "average" would suggest that further overall improvements can be made.

The Role of Race/Ethnicity in MCH Service Utilization

Simple Chi-squared tests were run for all 63 MCH services listed on the Focus Group Survey by participant's race (African American vs. non-Hispanic white). As noted above, 49 (42%) of the 117 focus group participants were African American; 51 (43%) were non-Hispanic-white. The 13 Hispanic participants were excluded from this analysis because of their small numerical representation. We did note earlier, however, that of these 13 Hispanic participants, 69% cited language and limited access to translation services as a barrier to obtaining medical care. Again, because of the nature of this research project, probability level for statistical significance was set at $p < 0.10$, two tailed.

African American vs. non-Hispanic White Utilization Patterns Significantly Different for 11 Services

These differences in service utilization percentages are summarized in Table 11 on the following page. For such MCH services as folic acid education, routine exams during pregnancy, breastfeeding counseling and assistance, child immunization education, utilization of Children's Special Services, and child immunizations, African American focus group participants are underrepresented in their percentage of utilization. On the other hand, for Parents Encouraging Parents, child abuse counseling, education/testing or treatment for sexually transmitted illnesses, HIV prevention/treatment, and parenting education, it is non-Hispanic whites who are underrepresented.

Understanding the reason behind the disparity of service utilization is beyond the scope of this study. However, the researchers strongly suggest that TDH-MCH investigate the determinants of this racial/ethnic disparity in type of MCH service utilized.

Table 11. MCH Service Utilization Patterns by Respondent's Ethnic Classification

Type of Service	% Use African American	% Use Non-Hispanic White
Prenatal Care: Folic Acid education for pregnancy	24	43
Prenatal Care: Routine exams during pregnancy	47	65
Postnatal Care: Breastfeeding counseling/asst.	24	41
Postnatal care: Child immunization education	33	55
Child/Adolescent Health: Children's Special Services	16	31
Child/Adolescent Health: Parents Encouraging Parents	22	8
Child/Adolescent Health: Child immunizations	49	69
Child Abuse Counseling	12	2
Adolescent Sexuality/Education/Family Planning: Education, testing or treatment for sexually transmitted illnesses	22	0
Adolescent Sexuality/Education/Family Planning: HIV prevention/treatment	12	2
Adolescent Sexuality/Education/Family Planning: Parenting education	37	8

Race/Ethnicity and Overall Satisfaction with the Availability MCH Services

No significant racial/ethnic differences were found in opinions concerning the "overall quality" of MCH services. However, statistically significant intergroup differences did exist concerning the "**overall availability**" of these services. Although both African-American and non-Hispanic white respondents tended to positively evaluate the overall availability of services received, **non-Hispanic whites are significantly more likely to hold this positive opinion** (see Table 12)**.** In fact, the Goodman and Kruskal's (1954) *gama* value of 0.49 can be interpreted to mean that 49% of the variation in participants' opinions concerning the availability of MCH services received is explained by having knowledge of respondent 's racial classification (African American vs. non-Hispanic white). This finding suggests the need for further study.

Table 12. African American vs. non-Hispanic White Response to the Question, "Overall, How Would You Rate the Availability of Services that You Need?" (N = 95)*

Racial/Ethnic Group	% Very Good	% Good	% Average	% Poor	% Very Poor
African American	24	23	49	2	2
Non-Hispanic White	52	23	23	2	0

*N African American = 47; N Non-Hispanic White = 48
Gamma = 0.49

The Role of Rural vs. Urban Location in MCH Service Utilization

One-hundred and eight of the 117 focus group participants could be unequivocally classified as " rural" (N = 38) or "urban" (N = 70) based on how TDH classifies Tennessee's 95 counties. Only 4 of the 63 MCH services listed on the Focus Group Survey form showed significant rural-urban differences in utilization patterns. These differences are summarized in Table 13.

Table 13. MCH Service Utilization Patterns by Respondent's Rural vs. Urban Location

Type of Service	% Use Rural	% Use Urban
Family Planning: Pregnancy Testing	50	68
Family Planning: and Counseling	27	50
Prenatal Care: Cesarean Birth	36	18
Child/Adolescent Health Services: Emotional Counseling	1	10

As shown in Table 13, 36% of rural focus group participants were significantly more likely, than their urban counterparts, to have delivered their infants by cesarean section. On the other hand, urban participants were significantly more likely to take part in family planning services, such as pregnancy testing and education and counseling. Urban participants were also more likely to have taken advantage of emotional counseling services, under the heading Child and Adolescent Health. TDH-MCH may want to look into factors that may be influencing these disparities.

Rural vs. Urban Location and Overall Satisfaction with the Quality of MCH Services

No statistically significant differences were found between rural and urban participants concerning their "overall satisfaction" with the availability of MCH services. However, with regard to "**overall quality**" of these services, a significant difference does exist. Although both groupings tended to positively evaluate the overall quality of MCH services, **rural participants are more favorable in their opinions**. The Goodman and Kruskal 's *gamma* of -0.21 can be interpreted such that 21% of the variation in opinions concerning the overall quality of MCH services can be attributed to the rural vs. urban locations of the 104 focus group participants.

Although statistically significant, the degree of explained association is not particularly strong. Thus, this finding may not be particularly salient.

Table 14. Rural vs. Urban Response to the Question, "Overall, How Would You Rate the Quality of Services that You Need?" (N = 104)*

Participant's Location	% Very High Quality	% High Quality	% Average Quality	% Low Quality	% Very Low Quality
Rural	24	44	31	1	0
Urban	22	22	50	6	0

*N Rural = 68; N Urban = 36
Gamma = -0.21

4. Examine MCH Program Capacity by Pyramid Levels

Describe and assess the State's capacity to meet the needs of the State's MCH population by level of the pyramid.

a. Direct Health Care Services

The federal government and Tennessee partner to improve services and activities for the MCH populations in need. The process of developing a needs assessment, planning, designing and implementing programs, and allocating resources is a critical part of the public health system in Tennessee. The Needs Assessment process has been described in Section II . Section IV demonstrates progress on national and state-selected performance measures. Refer to the pyramid "Core Public Health Services Delivered by MCH Agencies" (in attached file).

Tennessee has made every effort to directly tie the priority needs of the state and the national and state performance measures to the capacity and resource capability of MCH at the local, regional and central office levels. The direct health care services offered through the public health system are in response to identified needs and gaps in service for women, infants and children. The primary emphasis of all health department activity is to assure that women, infants, and children receive the preventive care they need to reduce morbidity and mortality.

Local health departments, especially in rural areas, continue to provide direct health care services for women, infants and children. Pregnancy testing, sexually transmitted disease screening, HIV counseling and testing, and family planning services are available in every county. All counties operate WIC and nutrition services. Individual and population-based health education about the continuing and emerging health care needs of women is readily available. Infants and children can receive immunizations and well child screenings in compliance with EPSDT. These examinations include blood lead level screening in compliance with the Child Health Manual standards and EPSDT guidelines. Local health department staff follow-up with all children having elevated blood lead levels through periodic monitoring, environmental and household inspection and lead abatement activities with the families.

For children and youth with special health care needs, local nurses assist the Genetics and Newborn Screening program when an infant residing in their county needs to be retested for any one of the required metabolic diseases. Children enrolled in the CSS program can receive basic well child care at the county health department with MCO approval, and the CSS care coordinators are based in each county to assist families with needed medical and referral services.

b. Enabling Services

Enabling services concentrate on access to care, care coordination, home visiting services, and newborn screening follow-up. Staff at the local, regional and central office levels continue to invest significant amounts of time assisting TennCare enrollees with complex TennCare issues. These TennCare activities include outreach and advocacy, determining presumptive eligibility for pregnant women and women with breast or cervical cancer, assistance with the appeals process, referring all CSHNC children for TennCare enrollment, and assuring that those presumptively eligible for prenatal care are receiving needed services. The care coordination component of CSS and the PEP Program provide special support and enable families to better meet their child's needs in a complex health care environment.

c. Population-Based Services

Population based services are available through the activities of MCH, Nutrition, Health Promotion and Communicable and Environmental Disease Sections of the Bureau. These services target groups of people rather than one-on-one contact or education. Examples include: newborn metabolic screening for all newborns; newborn hearing screening; surveillance for sexually transmitted diseases; adolescent health; childhood lead poisoning prevention program; the child fatality reviews system; SIDS counseling and autopsies; and adolescent pregnancy prevention program. Some services at this level of the pyramid are targeted at entire groups, such as the newborn screening program. Others take a population-based approach to surveillance, as in the case of persons with diagnosed STDs, and track contacts and provide treatment. Health education activities target even broader populations in hopes that repeated messages and information will result in positive lifestyle choices to prevent morbidity and mortality.

d. Infrastructure-Building Services

Tennessee's current infrastructure building activities concentrate on regional and county needs assessments, quality management, data and systems planning and the development or revision of standards and guidelines. Assessment for health planning is a statewide activity through the community health councils. Each county, and in turn each region, has developed a priority list of health needs based on data; groups develop and update implementation plans and activities to address these priorities on the local level. The Bureau has staff specifically assigned to develop and oversee the quality management (QM) structure which consists of local quality units, regional quality units and a state quality council. Regional quality teams facilitate and coordinate QM at regional and local levels. The data and systems planning functions have been greatly enhanced with the availability of SSDI funds which have been used to provide support for the statewide computer network.

Training of regional and local staff is a key role of the central office. In collaboration with Vanderbilt University's MIND (Mid-Tennessee Interdisciplinary Instruction in

Neurodevelopmental Disabilities) Training Program, MCH is conducting a year-long series of interactive training on MCH programs and health issues through video-conferencing statewide. This effort started with a plan for educating staff on the expansion of the newborn screening testing. MCH wanted to be assured that CSS and other health department staff were appropriately trained. Twelve videoconferences have been planned for the year addressing current information on specific diseases and conditions, along with the treatment or clinical applications.

See State's Narrative Section Agency Coordination for more detailed description of the above services.

5. Selection of State Priority Needs

A statewide meeting of MCH stakeholders was held in April 2005 to review MCH needs assessment findings and prioritize MCH state priorities for the block grant. Feedback from that meeting as well as the results of the needs assessment were shared during an internal TDOH MCH meeting that was attended by all MCH staff and several Bureau of Health Administration staff. Final MCH state performance measures were selected during that meeting based on data showing improvement in some 2000 state priorities and data reflecting new, unaddressed needs for the MCH population.

2005-2010 Tennessee Performance Measures

1. Increase percentage of children with complete Early Periodic Screening, Diagnosis, and Treatment (EPSDT) annual examinations by 3% each year.

The percentage of children receiving complete EPSDT exams has been increasing, but there is still a need to continue this trend in order to meet Healthy People 2010 goals. This performance measure with increase the delivery of direct health care services. Parents and children with special health care needs will benefit from increased screenings to identify and treat their child's medical condition. Children and adolescents will receive preventive care and access to treatment if needed. Mothers and their infants will also benefit from early and comprehensive preventive care.

2. Reduce incidence of maltreatment of children younger than 18 (physical, sexual and emotional abuse, and neglect) to rate no more than 8 per 1000.

Tennessee has a low rate of incidence of maltreatment of children younger than 18, but concerns about the accuracy and comprehensiveness of the current data surveillance system were deemed serious enough to continue this specific performance measure. We know that children and adolescents who access direct health care services are screened and referred for services if abuse is suspected. Also, enabling services such as home visiting, Project TEACH, CSS Care Coordination and Parents Encouraging Parents programs address abuse issues. Within the population-based services of community prevention initiatives, SIDS counseling, Child Fatality Reviews, Adolescent Health and Abstinence Only Education programs, the issues of abuse are addressed. As a part of the infrastructure building services, Child Care Re source Centers staff provide chills abuse prevention services to child care staff and parents. All three

MCH target population groups (women, mothers and infants; children and adolescents; and children with special health care needs) receive these services.

3. Reduce the number of babies born prematurely.

Reducing the number of babies born prematurely is a new state performance measure. Tennessee has a high rate of babies born prematurely and the rate is increasing instead of decreasing. Direct Health Care Services such as perinatal services and primary care services for women are addressing this issue. Enabling services such as home visiting provide preventive information for young mothers. All three MCH target population groups are affected by babies born prematurely whether it is the parents struggling with caring for a high risk baby, babies possibly born with special health care needs, or babies that grow into children and adolescents with learning disorders or other side effects resulting from their birth status.

4. Reduce the number of pregnant women who smoke and use illicit drugs.

Reducing the number of pregnant women who smoke and use illicit drugs is a new state performance measure. The correlation between negative birth outcomes and the use of tobacco and illicit drugs is significant. Therefore, this state performance measure was selected to help address infant mortality and prematurity birth rates. This issue will be addressed through the provision of Direct Health Care Services (Perinatal and Primary Care Services) for adolescents and women. Enabling Services such as home visiting and SIDS counseling provide pregnancy health education. Population-based services such as community prevention initiatives and adolescent health program provide prevention education to adolescents and young adults. This performance measure targets women of child bearing age.

5. Reduce the number of overweight and obese children and adolescents.

Reducing the number of overweight and obese children and adolescents is a new state performance measure. Tennessee has a high rate of obesity among children and adolescents and the rate has been steadily increasing. Direct Health Care Services such as primary care services for children and adolescents, CSS specialty clinics and EPSDT exams address overweight and obesity issues with their clients. Educational materials, nutrition and activity counseling and referrals to community services are provided as needed. Enabling Services such as CSS Care Coordination provide their clients with wellness education and referral to obesity-related services if needed. Population-based services such as the community prevention initiatives, adolescent health program and abstinence only education projects provide wellness education counseling and materials. Local and regional health councils are providing community-based prevention initiatives for this population group and child care resource centers are providing training and educational materials to child care staff and parents of young children (Infrastructure Building Service). This state performance measure targets children and youth in general and CSS children and youth.

6. Reduce the proportion of teens and young adults (ages 15-24) with Chlamydia Trachmomatis infections attending family planning clinics.

The number of teens and young adults with Chlamydia Trachmomatis infections attending family planning clinics has been increasing. This is due in part to new, more sensitive laboratory screens that detect the presence of Chlamydia earlier. Direct Health Care Services such as STD clinics and Primary Care Services for adolescents and young adults provide treatment and education services. Population-based Services such as STD Surveillance System, adolescent

health, abstinence only education and teen pregnancy prevention programs provide STD data collection and analysis services as well as prevention/ education services. This state priority affects primarily the general adolescent and young adult population.

7. Increase percentage of adolescents with complete Early Periodic Screening, Diagnosis, and Treatment (EPSDT) annual examinations by 3% each year.

This is a new state performance measure. The percentage of adolescents receiving complete EPSDT exams has been increasing, but there is still a significant need to continue this trend in order to meet Healthy People 2010 goals. This performance measure with increase the delivery of direct health care services through the EPSDT program. The adolescent health program within the population-based services category provides training and consultation services to increase adolescent EPSDT outreach and referrals. Adolescents with special health care needs will benefit from increased screenings to identify and treat their medical condition. Adolescents will receive preventive care and access to treatment if needed.

8. Reduce the number of high school students using tobacco. (cigarettes and smokeless)

The use of tobacco among high school students has been declining but since most people start to smoke during their teen years, it was decided that this remained a high MCH priority. Direct health care services such as primary care services and EPSDT screenings provide opportunities for tobacco prevention education. The adolescent health program within the population-bases services category provides smoking prevention and cessation educational material to clinic staff as well as provides data analysis and distribution to policy makers regarding this adolescent health issue. This state priority affects primarily the general adolescent population as well as adolescents who have special health care needs and youth who are pregnant or nursing.

9. Reduce the number of high school students using alcohol.

The use of alcohol among high school students in Tennessee has been declining but the correlation between adolescent risky sexual behavior and alcohol use remains significant so it was determined to keep this performance measure. During the provision of EPSDT services (Direct Health Care Services), adolescents can be screened for alcohol use/abuse. If so indicated, alcohol treatment and education services are accessed to support the adolescent. Through the provision of MCH population-based services such as community prevention initiatives and adolescent health program, alcohol prevention and education services are provided from health department staff as well as community-based organizations. This state priority affects primarily the general adolescent population as well as adolescents who have special health care needs and youth who are pregnant or nursing.

10. Increase the number of youth with special health care needs, age 14 and older, who receive formal plans for transition to adulthood.

This is a new state performance measure. The fact that the greater majority of children with special health care needs now live to adulthood, but are less likely than their non-disabled peers to complete high school, attend college or to be employed necessitates more focus. Enabling Services such as CSS Care Coordination will provide formal, written transition plans and coordinate the implementation of these plans. Population based services such as developing regional and local Transition Councils to help increase and facilitate community resources for the successful transitions of the youth.

C. Needs Assessment Summary

SUMMARY OF THE NEEDS ASSESSMENT PROCESS

Tennessee's Needs Assessment process covered eighteen months- January 2004 through May 2005. The process consisted of major efforts by MCH staff to develop a clear, comprehensive, well-formulated plan to identify the needs and subsequently develop priorities to help meet the needs of its pregnant women, children and infants. The State recognized the need to enhance and expand the process used in 2000. It was decided that two major elements, a survey of the State's professionals who provide services and a survey of citizens and potential consumers of the services, were needed to identify needs and gaps in services. The survey of professionals covered participants in multiple public and private agencies beside the Department of Health. The focus groups were statewide and equally divided into the three geographic grand divisions to potentially limit geographic bias. This important primary data would be utilized along with the State's secondary data sources to develop a true picture for Tennessee. In addition to the collection and analysis of data, Tennessee identified a fairly large, diverse and very committed group of MCH stakeholders from all across the state who reviewed that data and made recommendations of potential State priorities. This review of data culminated in a day long meeting in which the stakeholders were divided into in six small groups, two groups each addressing - 1) children and youth with special health care needs, 2) pregnant women, mothers and infants; or 3) children. From these three focal points, priorities were recommended. This insured that a much more comprehensive voice than the Title V staff was expressed.

NEEDS ASSESSMENT PARTNERSHIP BUILDING

Given the limited time frame, we could not involve community members to the extent that we had wished. However, we were able to garner community participation through interaction with focus group members in 12 locations, divided equally across the State's three grand divisions and including a Spanish speaking focus group. In addition, we had a large percentage of invited members participate in the sharing of primary and secondary data during a day long MCH Advisory ("Stakeholder") group meeting in Nashville. This Advisory group consisted of a number of members of the Tennessee's Early Childhood Comprehensive System (SECCS) planning committee. This insured consistency, and avoided duplication in other current and on-going planning process in the state. MCH agency personnel also participated indirectly through their responses to the Professional Stakeholder Survey. Community-level MCH staff members were involved in the selection of client-participants for each focus group meeting; findings from these meetings will be shared with the agencies in question upon approval from the MCH Director.

After the Nashville presentation of preliminary MCH needs assessment findings, advisory group members participated in small group "roundtable" discussions in which these findings served as a springboard for recommending MCH priorities for the next five years. This advisory group, consisting of MCH professionals throughout Tennessee, agreed to serve for two year staggered terms. In the fall of 2005, the MCH Advisory Committee will meet to discuss the implementation of the State priorities and to serve as a continuing resource regarding MCH decisions made at TDH-MCH.

JUSTIFICATION OF NEED BY MCH POPULATION GROUP

Data collection included the use of MCH-related websites, the development and distribution of a Professional Stakeholder Survey, the construction of a brief survey for focus group participants, and the formulation of a standard set of open-ended questions to be asked at each 90-minute

focus group session. As noted above, all data gathering, survey instrument development, and focus group information gathering was directly tied to the National and State MCH Performance Measures, and, to a somewhat lesser extent, HP 2010 MCH-related outcomes. The entire data-gathering process was also profoundly influenced by information obtained in meetings with TDH-MCH staff members. The data was sorted into the three aforementioned focal areas and given to the appropriate small groups as divided in the April 2005 MCH Advisory Stakeholder's Meeting in order to assist in prioritizing state priorities. The resulting recommendations from that meeting, as well as the results of the needs assessment were shared during an internal TDOH MCH meeting that was attended by all MCH staff and several Bureau of Health Administration staff. Final MCH state performance measures were selected during that meeting based on data showing improvement in some 2000 state priorities and data reflecting new, unaddressed needs for the MCH population.

The most significant change from the 2000 state performance measures selection process was the primary data assessments conducted for MCH by MTSU staff. The needs assessment information provided more extensive and representative data reflecting the views of both MCH providers and clients. Also, the formation of a statewide advisory committee to provide input into the selection process was not conducted previously.

2005-2010 STATE PERFORMANCE MEASURES

1. Increase percentage of children with complete Early Periodic Screening, Diagnosis, and Treatment (EPSDT) annual examinations by 3% each year.

2. Reduce incidence of maltreatment of children younger than 18 (physical, sexual and emotional abuse, and neglect) to rate no more than 8 per 1000.

3. Reduce the number of babies born prematurely. (NEW)

4. Reduce the number of pregnant women who smoke and use illicit drugs.(NEW)

5. Reduce the number of overweight and obese children and adolescents.(NEW)

6. Reduce the proportion of teens and young adults (ages 15-24) with Chlamydia Trachmomatis infections attending family planning clinics.

7. Increase percentage of adolescents with complete Early Periodic Screening, Diagnosis, and Treatment (EPSDT) annual examinations by 3% each year.(NEW)

8. Reduce the number of high school students using tobacco. (cigarettes and smokeless)

9. Reduce the number of high school students using alcohol.

10. Increase the number of youth with special health care needs, age 14 and older, who receive formal plans for transition to adulthood

2000–2005 STATE PERFORMANCE MEASURES DROPPED FROM 2005-2010 LIST

1. Reducing the number of HIV infected infants to no more than one per year.

2. After implementation of folic acid education at state, regional, and local levels, reduced the number of neural tube defects births.

3. Reduced to no more than 4% elevated blood lead levels in children 6-72 months of age who are screened.

Appendix A – MCH Advisory Committee

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Outlaw, Freida	Ph.D.	Mental Health Disabilities	312 8th Avenue North	Nashville
Palmer, Fred	M.D.	University of TN Boling Center	711 Jefferson Avenue	Memphis
Pangle, Mary Ann		Tennessee State University	330 10th Ave. North, Box 138	Nashville
Perry-Burst, Carolyn L.		Knox County Health Department	140 Dameron Avenue	Knoxville
Puckett, Susan	Education Consultant	Dept of Children's Services Education	1200 Foster Avenue	Nashville
Quick, Beth	Associate Professor	TN State Univ. Teaching & Learning	3500 John A. Merritt Blvd.	Nashville
Renfro, Audrey Jean		Dept. of Health Community Services	425 5th Avenue North	Nashville
Roberts, Mary Lou	Board Member	Sing To Read Literary Project	1309 Twin Springs Drive	Brentwoo

Ryan, Laurel	Family Support Coord.	University of TN Boling Center	711 Jefferson Avenue	Memphis
Sease, Treva	Parent		1820 Kerr Avenue	Memphis
Seivers, Lana	Commissioner	TN Department of Education	710 James Robertson Parkway	Nashville
Sharp, Pamela	NAFCCN Pres.	Pam's Group Child Care Home	1001 W. Greenwood Avenue	Nashville
Shields, Yolanda	Family Svcs Coordinator	Metro Action Commission	1624 5th Avenue North	Nashville
Slade, Patricia	Health Services Coord.	Department of Children's Services	436 6th Avenue North 7th fl.	Nashville
Smith, Gerri		Bethlehem Centers	1417 Charlotte Avenue	Nashville
Stuart, Kim		Quality Childcare Initiative	1624 5th Avenue North	Nashville
Suggs, Sharon	Nutrition Coordinator	Metro Action Comm. Head Start	1624 5th Avenue North	Nashville
Sullivan, Julie	Family Resource	Tennessee Family Voices	2465 Bybee Chapel Road	Rock Islan
Sweeney, Millie	Program Coordinator	Tennessee Voices for Children	1315 8th Avenue South	Nashville
Swinford, Lynette	Fiscal Manager	Council on Developmental Disabilities	A. J. Bldg, 13th fl., Ste. 1310	Nashville
Temple, Patricia	M.D.	Vanderbilt Children's Hospital	2200 Children's Way	Nashville
Thompson, Don	Director	Tennessee Infant Parent Services	2725 Island Home Blvd.	Knoxville
Timm, Matt	Program Director, Ph.D.	Tennessee Voices	1315 8th Avenue South	Nashville
Venson, Brenda	Program Manager	Metro Social Services Childcare	611 Stockwell Street	Nashville
Voychehovski, Tom	M.D.	Hamilton Pediatrics	7405 Shallowford Rd., Ste. 240	Chattanoog
Wade, Patricia		TN Commission on Children & Youth	710 James Robertson Parkway	Nashville
Watson, Gwendolyn	Urban Educ. Specialist	TN Department of Education	710 James Robertson Parkway	Nashville
Weber, Claudia	Consultant	Special Education Division	710 James Robertson Parkway	Nashville
Webster, Suzette	Parent	Moms 4 Overcoming	1508 Fall Drive	Nashville
West Wall, Barbara	Director	Signal Centers	422 Bill West Road	Limeston
Wheeler, Mary		Tennessee Family Voices	1142 Ridge Ct.	Jonesboro
Wilbur, Ellyn		Megallan Health Services	222 2nd Avenue South	Nashville
Williams, Brenda K.		Comm. Institute of ECCS	777 Washington Avenue	Memphis
Williams, Elizabeth	Disparities Eliminator	TN Department of Health	425 5th Avenue North, 4th fl.	Nashville
Williamson, Sandy		Tennessee Department of Education	710 James Robertson Parkway	Nashville
Wilson, Katie	Complaint Coordinator	TennCare	310 Great Circle Road	Nashville
Wolery, Ruth	Asst. Prof. of Special Ed.	Susan Gray School @ Vanderbilt	110 Magnolia Circle	Nashville
Wood-Oguno, Ginger	Executive Director	Tomorrow's Leader's Preschooler	830 Kirkwood Avenue	Nashville
Wyche-Etheridge, Kimberlee	Director, MCH Metro	Government of Nashville / Davidson	311 23rd Avenue North	Nashville
Yoder, Kathryn	CCR&R	Tennessee State University	3500 John A. Merritt Blvd.	Nashville
Greg Yopp	Director	Children's Special Services	425 5th Avenue North, 5th fl.	Nashville

Appendix B- Professional Survey

MATERNAL AND CHILD HEALTH NEEDS ASSESSMENT
PROFESSIONAL STAKEHOLDER SURVEY

DIRECTIONS: The following is a list of issues or concerns related to Maternal and Child Health. For each issue, please check the answer box(es) for which you think the issue is HIGHLY IMPORTANT. You may check none of the boxes for a given issue or multiple boxes for a given issue. For each issue, ***check Box (A)*** *if YOU consider the issue to be HIGHLY IMPORTANT to either the community or region served by your agency;* ***check Box (B)*** *if you think that a significant number of YOUR CLIENTS would consider this issue to be HIGHLY IMPORTANT;* ***check Box (C)*** *if your agency CURRENTLY ADDRESSES this issue;* ***check Box (D)*** *if your agency DOES A GOOD JOB addressing this issue; and* ***check Box (E)*** *if your agency DOESN'T ADDRESS this issue BUT SHOULD.*

Issue	(A) Highly Important to Community or Region	(B) Highly Important to Significant # Clients	(C) Agency Currently Addresses Issue	(D) Agency Does Good Job on Issue	(E) Agency Doesn't Address but Should
1. Newborn screening and follow-up for infant hearing and serious genetic/medical conditions					
2. Breastfeeding rates					
3. Infant mortality rate					
4. Low and very low birth weight babies					
5. Early and adequate prenatal care					
6. Neural tube defects among infants					
7. HIV-infected infants					
8. Unintended pregnancy – women of all ages					
9. Healthy spacing of pregnancies					
10. Maternal deaths due to pregnancy complications					
11. Maternal illnesses due to pregnancy complications					
12. Attendance by pregnant women and partners in a childbirth education series					
13. Rate of cesarean births among low risk women					
14. Preterm birth rate (before 37 weeks gestation)					
15. Appropriate weight gain among					

Issue	(A) Highly Important to Community or Region	(B) Highly Important to Significant # Clients	(C) Agency Currently Addresses Issue	(D) Agency Does Good Job on Issue	(E) Agency Doesn't Address but Should
pregnant women during their pregnancies					
16. Healthy, full-term infants who are placed on their backs to sleep					
17. Tobacco use among pregnant women					
18. Alcohol and illicit drug use among pregnant women					
19. Fetal alcohol syndrome					
20. Pregnant women and children exposed to second-hand smoke					
21. Young children receive full schedule of age appropriate immunizations					
22. Teenage pregnancy rate					
23. Dental care for children					
24. Child and youth death rates					
25. Adolescent deaths due to suicide					
26. Children without medical insurance					
27. Children with elevated blood lead levels					
28. Tobacco, alcohol, and drug use among youth					
29. Maltreatment of children including physical, sexual, and emotional abuse					
30. Early, Periodic, Screening, Diagnosis & Treatment (EPSDT) annual exams for all children in need					
31. Sexually transmitted diseases among youth					
32. Occurrence of developmental disabilities among children					
33. Families of Children with Special Health Care Needs (CSHCN) partner in decision-making, satisfied with services they receive					
34. CSHCN receive coordinated, ongoing, comprehensive care within a medical home					
35. Families of CSHCN have adequate private or public insurance to pay for needed services					
36. Families of CSHCN report community-based service systems are organized, can be used easily					

Issue	(A) Highly Important to Community or Region	(B) Highly Important to Significant # Clients	(C) Agency Currently Addresses Issue	(D) Agency Does Good Job on Issue	(E) Agency Doesn't Address but Should
37. Youth with special health care needs receive necessary services to make the transition to all aspects of adult life					
38. Transportation issues and proximity to services					
39. Language issues, access to translation services					
40. Services available at varied times of day					
41. Education level of parents					
42. Education level/success of children and youth					
43. Nutrition and obesity among children, youth, and families					
44. Physical activity and fitness for children, youth and families					
45. Injury prevention and safety					
46. Consistent, stable place to live/shelter					
47. Economic stability of family					

48. Looking over the list of issues you marked as HIGHLY IMPORTANT to your ***community or region,*** determine, by the issues' identifying numbers, the three issues you consider to be **most important**. For example, if one of your top issues is Injury Prevention and Safety, list issue #42.
    Issue #1 _____ Issue #2 _____ Issue #3 _____

49. Looking over the list of issues you marked as HIGHLY IMPORTANT to a ***significant number of your clients,*** determine, by the issues' identifying numbers, the three issues you think your clients would consider **most important**.
    Issue #1 _____ Issue #2 _____ Issue #3 _____
50. Looking over the list of issues you identified as ***currently being addressed by your agency,*** determine, by the issues' identifying numbers, the three issues you consider to be **most important**.
    Issue #1 _____ Issue #2 _____ Issue #3 _____

51. Looking over the list of issues you identified that your ***agency does a good job addressing,*** determine, by the issues' identifying numbers, the three issues you consider to be **most important**.
    Issue #1 _____ Issue #2 _____ Issue #3 _____

52. Looking over the list of issues you identified that ***should be addressed by your agency but are not addressed at this time,*** determine, by the issues' identifying numbers, the three issues you consider to be **most important**.
    Issue #1 _____ Issue #2 _____ Issue #3 _____

53. If you wish to say more about any of your responses, or if there are other issues of interest to you, your clients, or your agency, tell us about them here. ***(Please be as specific as possible to help us with data coding. Feel free to use the back of this page if you need more room.)***

_____

_____

_____

_____

_____

54. In what department or organization do you work?
    - ❑ Council on Developmental Disabilities
    - ❑ Department of Children's Services
    - ❑ Department of Education
    - ❑ Department of Health
    - ❑ Department of Human Services
    - ❑ Department of Mental Health/ Developmental Disabilities
    - ❑ Division of Mental Retardation
    - ❑ Tennessee Commission on Children and Youth
    - ❑ Private health related agency/organization (***please specify***) _____
    - ❑ Private social services related agency/organization (***please specify***) _____
    - ❑ Other (***please specify***) _____

55. On what Advisory Group(s) do you serve?
    - ❑ None
    - ❑ Child Fatality Advisory Committee
    - ❑ Children's Special Services Advisory Committee
    - ❑ Genetics Advisory Committee
    - ❑ Perinatal Advisory Committee
    - ❑ Women's Health Advisory Committee
    - ❑ Other (***please specify***) _____

56. In what county of Tennessee is your agency/organization located? _____

57. In what capacity do you work ***most*** of the time?
    - ❑ Administrator or manager
    - ❑ Direct service with clients
    - ❑ Other (***please specify***) _____

58. What is your specific job title (for example: Nurse, Social Worker, Program Director) _____

_____

Thank you for your time in completing this questionnaire

Appendix C- Focus Group Survey

Focus Group Participant – Consent letter (in Spanish also)

March 8, 2005

Dear

We are so pleased that you have agreed to join our focus group discussion. The purpose of the group is to get your opinions about maternal and child health care in your community. We want to know what you think are the strengths and weaknesses of the services you have used and how well they are meeting your and your family's needs. We also want to know what services are most important to you now and if there are programs that you would like to see developed in the future. If you have important needs that are not being met at this time we'd like to know about that too.

Yours is one of 12 focus group meetings being conducted throughout Tennessee by staff from Middle Tennessee State University (MTSU). The information that you and others provide to MTSU will help the Tennessee Department of Health make its plans and develop needed services for the next several years.

To show our appreciation for your time, we will provide you with a $25.00 gift card, which will be given to you at the end of the focus group discussion. Lunch or refreshments will also be provided. If you need help paying for babysitting, transportation, or translation assistance so that you can attend the meeting, please call me at

The details for your group are listed below.

Date of Group: March _____, 2005

Time of Group: _____

Meeting Location: _____

Thank you!

Sincerely,

Focus Group Survey (in Spanish also)

Focus Group Questions for MCH Needs Assessment

For our first question, please take a look at the list of services you received when you first arrived. I'd like to go around the room and ask each person to identify 1-2 services they use right now or have used in the last 6 months. *Follow-up, once everyone has offered something,* have any of you used other services that haven't been discussed or listed yet? *List from group should be written down on an easel sheet as folks are listing them.*

Think back to the last time you needed services for yourself or your family and had a **good experience**. These services could be a Department of Health program such as those we just discussed, or it might be something routine like a doctor's visit. Think about how pleased you were with the service. What made it a positive experience?

Now I'd like you to think back to the last time you needed services and had a **negative experience**. What made it a bad experience? What might have made it better?

Please think about a recent situation in which you needed some kind of service or assistance for yourself or for a family member and **couldn't get the help you needed**. What was the service? Was it for yourself, for your child or for another family member? Why wasn't the service available? How did you handle the situation when you couldn't get what you needed?

I'd like to talk about how important these services are to you. Look at the list of services you developed earlier in our meeting. Of all the services you currently use or have used in the past, which are **most important** to you or your family? Please explain.

Now, thinking about the assistance you mentioned you needed but couldn't obtain or wasn't available to you of your family, which of these would be most helpful to you now? Please explain.

We've talked a lot about the services you or your family has used and also about assistance you have wanted or needed but could not obtain. I'd like to shift gears a bit and give you an opportunity to think about these services as they relate to your communities. We hear stories in the news about changes in TennCare and about the lack of funds for many health and social se4rvices programs. If you were in charge of maternal and child health services in your community, to what programs would you give top priority?

Is there anything else you'd like to tell us?

Prepared January 18, 2005

Location: _____ Date: _____

Focus Group Information Form
Tennessee Maternal and Child Health Needs Assessment

Please take a moment to fill out this form on your background and use of services. All information will be grouped and reported anonymously, DO NOT WRITE YOUR NAME ON THIS PAGE. Thank You!

BACKGROUND INFORMATION

County of Residence:

Age: _____ 3. Sex F M

Number of persons living in your household *(write in number in each age group)*:
Children under 6 years of age:
Children ages 6-11:
Children ages 12-17:
Adults (ages 18 and older):

What is the ***highest level*** of education you completed?
Elementary school
Some high school
Graduated high school or GED
Some college
Graduated 4-year college
Graduate education after college
Graduate degree

Race/ethnicity *(check all that apply)*:
Black or African American
Native American
Asian or Pacific Islander
White/Caucasian
Hispanic
Other (please specify):

In which of these groups did your total household income ***from all sources*** fall last year--before taxes that is? Just check the range that comes closest to your total household income for last year (2004).

USE OF SERVICES

Check ***all*** of the following Maternal and Child Health Services and experiences you or your children have ***ever*** received:

8-10. Women's Health

Family Planning
Pregnancy testing
Education and counseling
Medical examinations
Lab tests
Contraceptive supplies
Treatment for sexually transmitted illnesses

Other (please specify):

Prenatal Care (prior to birth)
Pregnancy testing
Pregnancy and childbirth education classes
TennCare enrollment
WIC referral or enrollment (nutrition/food program for Women, Infants, and Children)
Obstetric medical management referral (you were ***assigned*** to a physician/clinic)
Nutrition education for pregnancy
Folic acid education for pregnancy
Routine medical exams for pregnancy with doctor
Routine medical exams for pregnancy with midwife
Education regarding appropriate weight gain in
pregnancy
Education to prevent premature birth of baby
Prenatal care beginning in the first trimester of pregnancy
Care for gestational diabetes, high blood pressure or other illness in pregnancy
Breastfeeding education
Cesarean birth
Education about second hand smoke exposure for pregnant women and children
Smoking cessation program for pregnant women who smoke
Education about or treatment for drug use or alcohol use during pregnancy
Parenting education
Other (please specify):
Postnatal Care (after birth of newborn)
For mother, medical check-ups
For newborn, medical check-ups
Breastfeeding counseling/assistance
Care for low birth weight infant
SIDS education (sudden infant death syndrome)
Care for HIV-infected infants
Education for full schedule for age appropriate child immunizations
Information on healthy spacing of children
Parenting education
Other (please specify):

11. Genetic And Newborn Screening Services

Newborn screening for infant hearing, genetic, or medical problems
Other genetic screening services
Diagnostic testing
Counseling services for individuals at risk for genetic disorders
Other (please specify):

12. Child And Adolescent Health Services

TennCare enrollment
Children's Special Services (for children with disabilities, chronic illnesses or special healthcare needs)
Routine medical services
Parents Encouraging Parents program (for parents of children with special healthcare needs)
Lead poisoning testing, treatment, or education
Home lead inspection and/or risk assessment
Tennessee Healthy Start program or other home visiting program
Routine immunizations for child(ren)
Flu shots for child(ren)
Dental exams, cleanings, services
Eye exams, services
Nutrition, obesity prevention, and physical education
Childhood diabetes education and services

Counseling for children with emotional or life transition problems
Counseling for sexual, physical, or emotional abuse
Program to prevent use of tobacco, alcohol, and drugs among youth
Injury prevention and safety education
Other (please specify):

13. Adolescent Sexuality Education and Family Planning Services

Abstinence education
Family planning and contraception information
Annual gynecological examination
Education, testing or treatment for sexually transmitted illnesses
HIV/AIDS prevention, testing, or treatment
Contraceptive supplies
Parenting education
Pregnancy prevention program
Other (please specify):

SATISFACTION WITH SERVICES

Have any of the following been problems for you or your family in receiving needed services? (Check all that apply):
Transportation and location of services
Language barriers, access to translation services
Services available at varied times of day
Education or knowledge about services and how to get them
Insurance or ability to pay for services
Other (please specify): _____
_____

Overall, how would you rate the ***availability of services*** that you need?

Very poor
Poor
Average
Good
Very good

Overall, how would you rate the ***quality of services*** that you have received?

Very low quality
Low quality
Average quality
High quality
Very high quality

Please return your completed form
in the envelope provided.
Thank you!